NEW JERSEY MEDICINE

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THE JOURNAL OF THE MEDICAL SOCIETY OF NEW JERSEY JANUARY 1991



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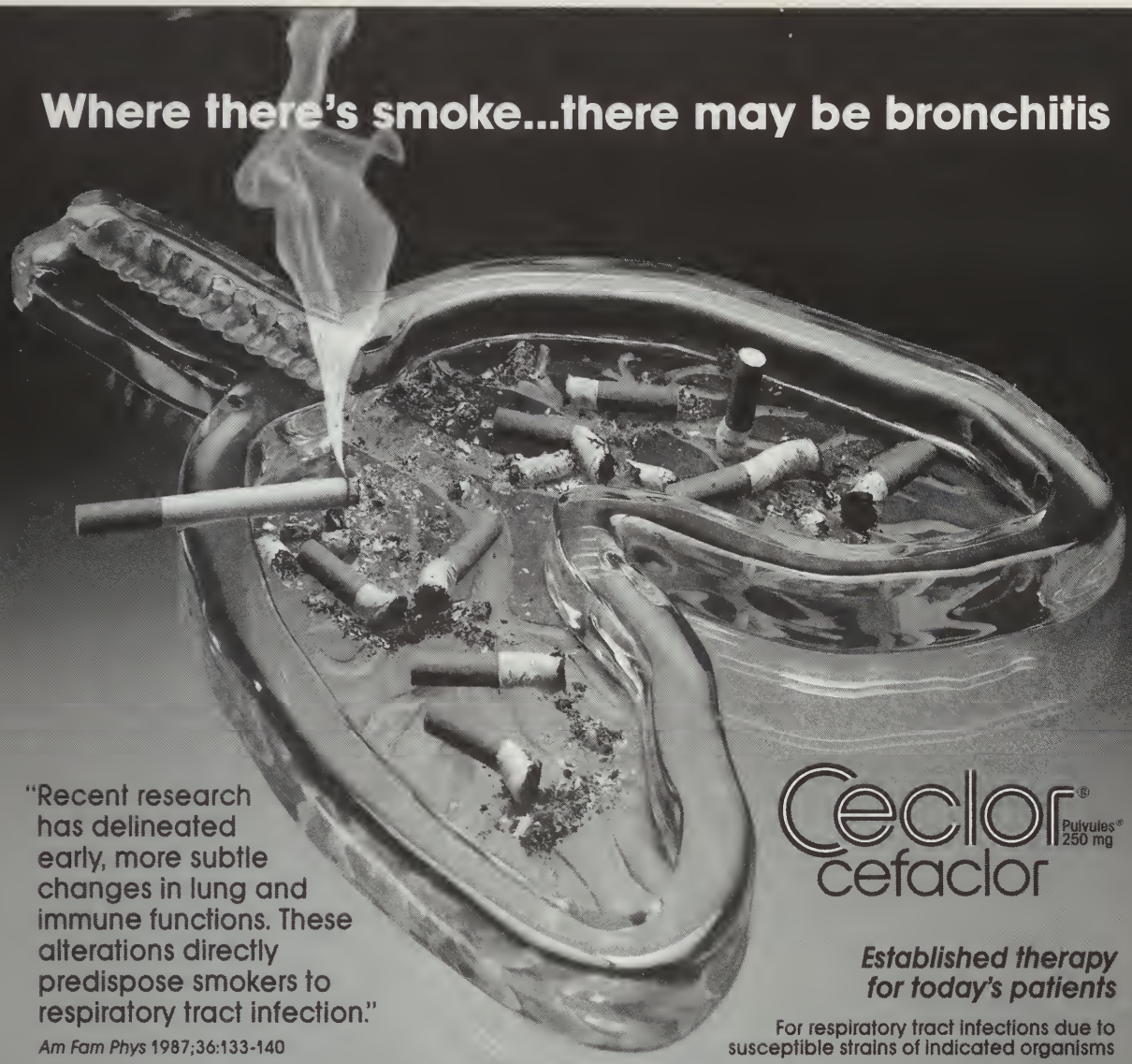


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• Stevens-Johnson syndrome, toxic epidermal necrolysis, and anaphylaxis have been reported rarely. Anaphylaxis may be more common in patients with a history of penicillin allergy.
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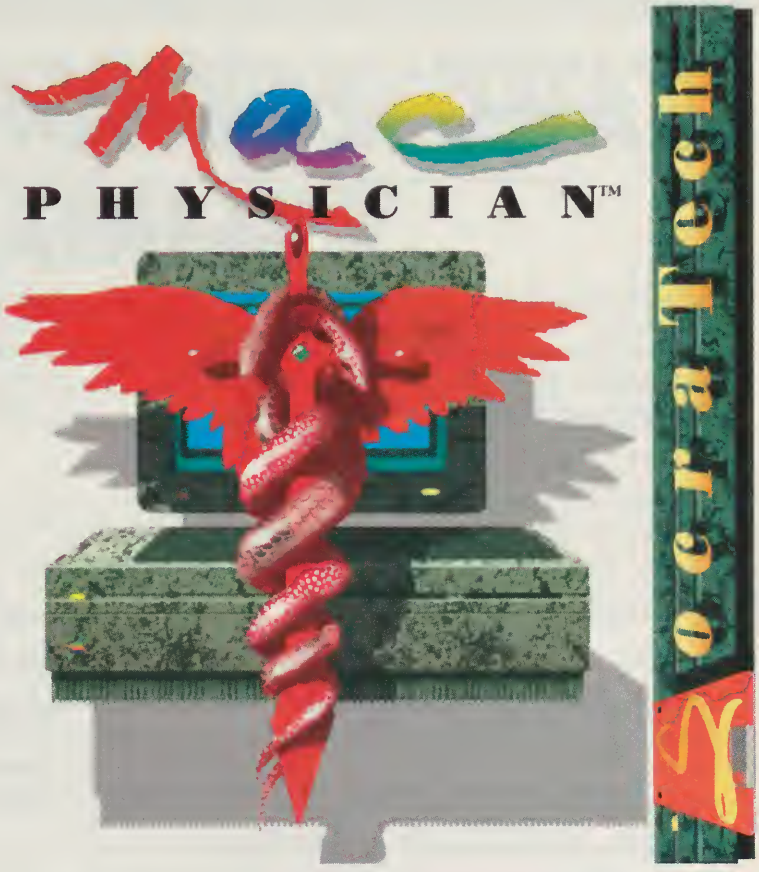
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MALPRACTICE IN THE UNITED KINGDOM: A COMPARATIVE APPROACH

The legal systems of the United States and the United Kingdom share similar common law roots. Recovery for malpractice in both systems typically is based on a negligence standard. It, therefore, is instructive to compare the medical malpractice trends of these two judicial systems.

In recent years, there has been a perceived crisis in the availability and affordability of medical malpractice insurance, tort reform legislation, as well as more radical proposals for discarding the common law tort system in favor of a no-fault or administrative claims system. Although a physician in the United States still is five or six times more likely to be sued for malpractice than a physician in the United Kingdom,[1] there currently is apprehension in the United Kingdom about a malpractice crisis. As a result of this concern, there have been recent calls for fundamental systemic reforms. This article will review some of the possible reasons for the disparity in litigation rates between the United States and the United Kingdom in the hope that a comparative approach will assist in a better understanding of the United States system and in evaluating reform proposals.

In the United Kingdom, the defense and indemnification for malpractice claims against physicians is provided by medical defense societies. These societies, the Medical Protection Society and the Medical Defense Union, differ from insurers in that they have discretion as to whether or not to defend and indemnify claims. In practice, however, the defense societies function similarly to insurers. Traditionally, defense societies have charged a single subscription rate for all physicians regardless of specialty. This is in contrast to the specialty-rating system common in the United States. Recently, however, specialty-rating was introduced in the United Kingdom.[2] The subscription rates for general practitioners are reimbursed by the National Health Service (NHS). NHS also has taken on the responsibility of providing indemnification for consultants (specialists) on the staff of NHS facilities.

The sense of an impending malpractice crisis in the United Kingdom has been engendered by substantial increases in subscription rates by the defense societies, in response to increased severity and frequency of claims. Although absolute levels of claim severity and frequency are significantly higher in the United States than in the United Kingdom,

recent rates of increase have been at least as high in the United Kingdom as in the United States.[3] Data from the Medical Protection Society indicate the number of claims increased from 1,000 in 1983 to 2,000 in 1987. Data from the Medical Defense Union indicate that the frequency of claims and claim severity doubled between 1984 and 1987.[4] Although malpractice insurance costs in the United States are roughly ten times greater than costs in the United Kingdom, recent rates of increase have been approximately the same in the United States and the United Kingdom. For example, in the United Kingdom the rate of increase for 1988 was 87 percent for junior physicians.[5]

These increases in claim severity and frequency and insurance costs in the United Kingdom are taking place despite the existence of a medico-legal culture that is less litigious than in the United States. In the United Kingdom, most health care is provided without charge by NHS.

Under NHS, everyone is entitled to the services of a general practitioner. Access to consultants and hospitals generally is by referral from the general practitioner. Frequently, there is a close personal relationship between the patient and the general practitioner. For example, it is not unusual for a general practitioner to make house calls. Moreover, physicians do not enjoy the high incomes that are common in the United States, which perhaps reduces the alienation between patient and physician. There also may be less inclination to sue for defective care which is perceived as being provided without charge. In addition, since medical care is provided by the state, medical expenses are not an element of damages in a malpractice lawsuit, further reducing the incentive to sue.

The consumer movement has not had the impact in the United Kingdom it has had in the United States. There has not been a British counterpart to Ralph Nader, and British consumers have not been as willing to assert their rights in court. There has been a deferential attitude toward professionals on the part of their patients that in part is due to the rigid class distinctions. These attitudes, however, may be changing as the British come to view themselves more as consumers of medical care and their expectations of health care increase. There also is a widespread belief that NHS has not been funded adequately under the Thatcher government. Consequently, there is a growing belief that the quality of medical care has suffered. This belief more readily may predispose victims of iatrogenic injury to seek relief in the courts.

In comparing the malpractice situations in the United States and United Kingdom, it is appropriate to take note of some of the differences between the legal systems. In the United Kingdom, malpractice cases are not tried before a jury. Instead, these cases are heard by a single judge who is not as likely to respond emotionally to the needs of a severely injured plaintiff. Traditionally, British judges have been drawn only from barristers who in turn have been drawn from the upper classes. British judges typically have an "Oxbridge" background, that is, they are products of elite educational institutions. There is a dearth of female and minority judges as well as judges from working class backgrounds. The existence of this "old boy" network may inculcate a deferential attitude by the judiciary towards the professional authority of physicians. There may be a tendency for British judges to more readily identify with the professional defendant accused of malpractice than with the injured patient.

The deferential attitude of British judges may be seen in the leading English case of Sidaway versus Bethlem Royal Hospital Governors,[6] that

dealt with the doctrine of informed consent. In this case, the patient was paralyzed as a result of an operation to relieve pain in her neck and shoulders. The surgeon had informed her of the risk of disturbing a nerve root, but failed to tell her of the risk of damaging her spinal cord. He also failed to tell her that the procedure was elective rather than a matter of necessity. In rejecting the prudent patient test adopted in Canterbury versus Spence,[7] Lord Bridge stated that "what degree of disclosure of risks is best calculated to assist a particular patient to make a rational choice must primarily be a matter of clinical judgment."[8] Likewise Lord Templeman stated that "the patient cannot complain of lack of information unless the patient asks in vain for more information or unless there is some danger which by nature or magnitude or for some other reason requires to be separately taken into account by the patient in order to reach a balanced judgment in deciding whether or not to submit to the operation."[9] Thus, in the context of informed consent, the British courts appear to prefer the value of beneficence over patient autonomy.

Another signficant distinction between the United States and the United Kingdom is the control of the rules governing attorneys' fees. In the United Kingdom, the contingency fee is prohibited by law. Furthermore, the loser is required to pay the attorneys' fees of the prevailing party as well as his own attorneys' fees. Undoubtedly, there are many potential claimants who are deterred from pursuing a malpractice claim by the prospect of paying attorneys' fees regardless of the outcome of the case. This discourages a plaintiff from bringing a lawsuit where liability is not clear or where the level of damages is not significant enough to warrant the exposure to liability for the payment of two sets of attorneys' fees.

Although the United Kingdom has a legal aid system that provides access to attorneys without charge or at a subsidized rate for those who meet its income criteria, it is doubtful that such a system provides access to the best lawyers specializing in malpractice, as does the contingency fee system in the United States. Under the contingency fee system, there is a strong incentive for the plaintiff's lawyer to screen the claim so as to insure that only high value claims are brought. The contingency fee also motivates the lawyer to more aggressively pursue the matter in order to achieve the maximum possible recovery. This may partially explain the difference between claim severity in the United States and the United Kingdom.

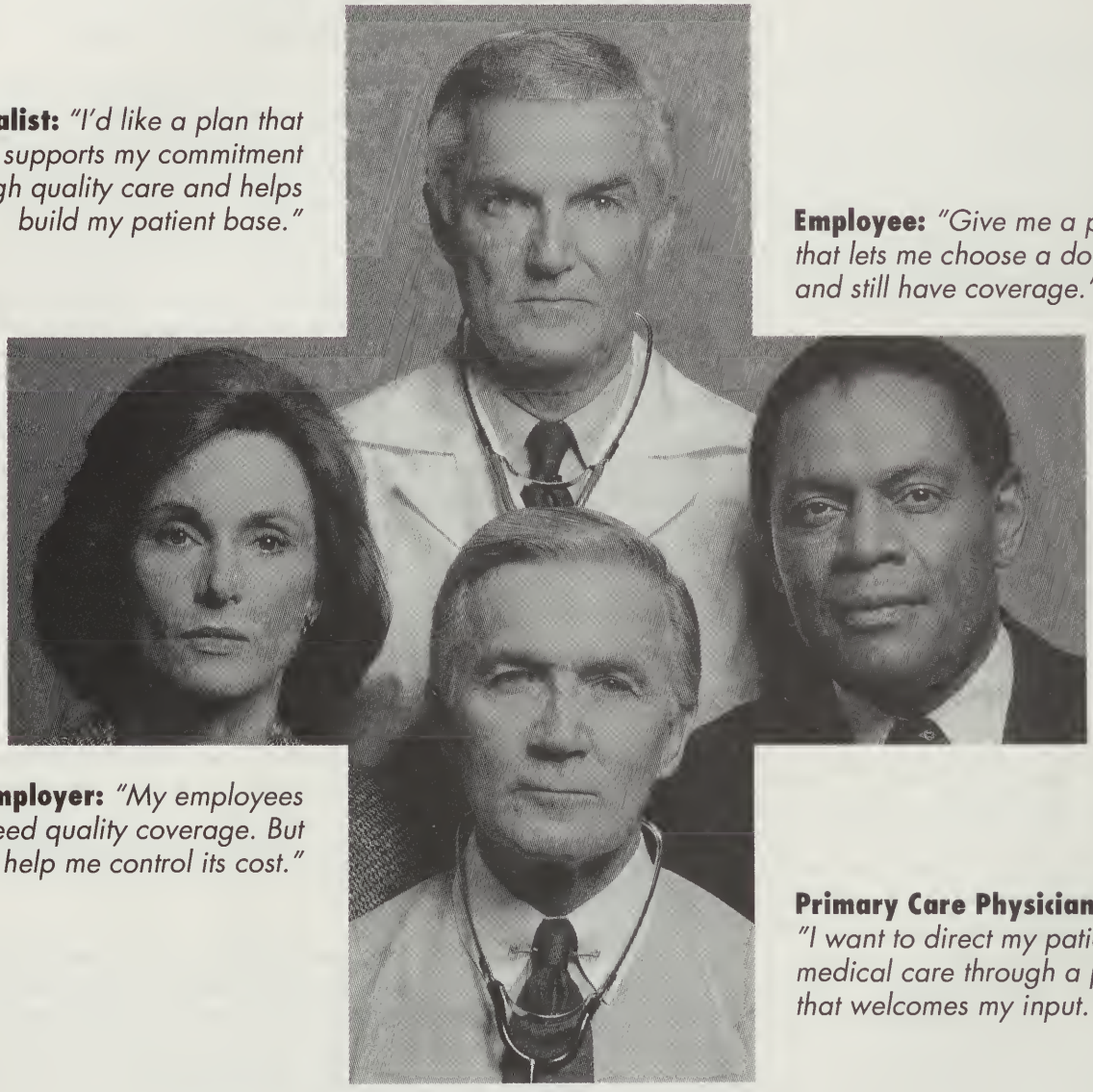
Another difference between the systems may result from the comparative difficulty in locating expert witnesses. In the United Kingdom, most physicians are employed by NHS. Obviously, this may make it more difficult for a plaintiff to obtain an expert witness. The presence of NHS as the common employer may augment a sense of collegiality and foster a conspiracy of silence.

In considering proposals for fundamental reform of the malpractice system in the United States, account should be taken of trends and developments in other legal cultures. The fact that claim frequency and severity are increasing at approximately the same rates in the United States and the United Kingdom, despite significant differences in the two legal systems, suggests that the malpractice crisis, in part, may be fueled by factors extraneous to the legal system. It is possible that rising expectations by consumers, changes in the practice of medicine, and trends that transcend national borders also are significant contributing factors that should be more closely examined before implementing reforms. References are available upon request. (Reprinted from *Medical Malpractice Reports,* October 1990) □

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MSNJ NEWSLETTER

STATE BOARD OF MEDICAL EXAMINERS

As the New Jersey State Board of Medical Examiners (SBME) begins the implementation of the Medical Conduct Reform Act, and as it receives information to be filed with the National Practitioner Data Bank, it anticipates that the number of investigations it will have to conduct will increase significantly. SBME recognizes that accomplishing its ever-expanding mission of protecting the public and assuring quality health care for New Jersey cannot be achieved without the interest and cooperation of the state's medical community. To that end, SBME is establishing a medical expert advisory panel. The panel will include practitioners from the state whose education, training, and experience allow them to be recognized as experts in their area of practice.

SBME will ask its experts to review the investigative file, that will include medical records; to prepare a medical opinion of the case; to cooperate with the state in the preparation of the legal case (if necessary); and to testify in those matters that proceed to a full hearing. It is anticipated that the panel will have two categories of experts; those who are willing to testify at a hearing and those who will submit written opinions only. Service on the panel will be pro bono. If you are interested in serving on the panel or have questions, please submit your resume to: Katherine M. Carroll, Assistant Executive Director, New Jersey State Board of Medical Examiners, 28 West State Street, Room 602, Trenton, New Jersey 08608.

INDEPENDENT LABORATORY SERVICES

The Division of Medical Assistance and Health Services (the Division) has submitted the *Manual for Independent Laboratory Services,* N.J.A.C. 10:61, that will appear in a future issue of the *New Jersey Register.* The proposal was submitted for readoption to comply with Executive Order No. 66 (1978), commonly known as the Sunset Provision. There are no textual changes associated with this readoption.

LIABILITY UPDATE

An AMA-drafted liability bill, that would mandate strong tort reforms as a matter of federal law, has the support of over 20 national health care and business associations. It was introduced in Congress in the summer of 1990. This bill addresses your major concerns, and includes: a $250,000 ceiling on noneconomic damage awards, limits on attorney contingency fees, and mandatory periodic payment of damages over $100,000. This bill deserves support. Call your senator—just dial 1/202/224-3121—and tell him you support the "Ensuring Access through Medical Liability Reform Act," S-2934.

ANTI-HASSLE BILL

The AMA-sponsored "anti-hassle" Medicare reform bill, HR-4475, now has 221 cosponsors and its Senate counterpart, S-2591, has 21 cosponsors. This legislation is designed to shield physicians from the excessive paperwork and regulatory demands they face. For example, it will: make release of carrier screens mandatory, permit billing for covering physicians, and allow medical societies to represent physicians in appeals of inappropriate denials. We will keep you posted on this AMA anti-hassle legislation.

PRACTICE PARAMETERS DEVELOPMENT

To maintain high-quality standards of health care, the AMA is actively supporting the development of practice parameters that are clinically relevant and practical enough to apply to daily practice. To date, efforts include: establishing a special partnership and forum with medical specialty societies to guide and coordinate parameter development; conducting a legal analysis that found that the use of parameters does not create any new liabilities for physicians and may even help physicians to better control their existing liability risks; and lobbying to keep the development of practice parameters in the hands of the medical profession, not the federal government.

NATIONAL DATA BANK CONCERNS

The AMA is taking action on many fronts to address physician concerns about the newly opened National Practitioner Data Bank (NPDB). To date, the AMA has achieved the following:

- The AMA has obtained passage of an amendment that tightly restricts plaintiff attorney access to the Bank.
- The AMA has successfully advocated confidentiality protections.
- Due to AMA intercession, voluntary enrollment in a physician impairment program is not reportable.
- AMA intercession has led to a reversal in policy so that no retroactive reporting of annuity payments will be required.

These activities represent only the first phase of a long-term commitment to addressing physician concerns with the Bank. For example, the AMA now is mounting an effort to stop the reporting of small malpractice payments to the NPDB. And, the AMA will use every possible means to block efforts to grant the general public or the media access to the Bank. If you would like more information on the NPDB, you can get a free copy of a brochure prepared for physicians by the AMA. Just call 1/800/262-3211 to order a copy.

CALL FOR PAPERS: SPECIAL ISSUE ON COMPUTERS

NEW JERSEY MEDICINE invites interested persons to submit articles or suggestions for a special issue on Computers in Medicine to be published in spring 1991. Under the guest editorship of Richard M. Ball, MD, this special issue will cover a variety of topics directed toward computer use by the physician. Specific topics for articles might include: medical infomatics; getting physicians to use computers; experiences using on-line medical databases; drug interaction programs; coding software; radiologic imaging; computer-assisted learning and testing; computer-stored medical records; doctors as programmers; and personal experiences with office business computer systems. Please send your inquiries or manuscripts to Richard M. Ball, MD, 1907 Park Avenue, South Plainfield, NJ 07080.

PHYSICIAN OFFICE LABORATORY

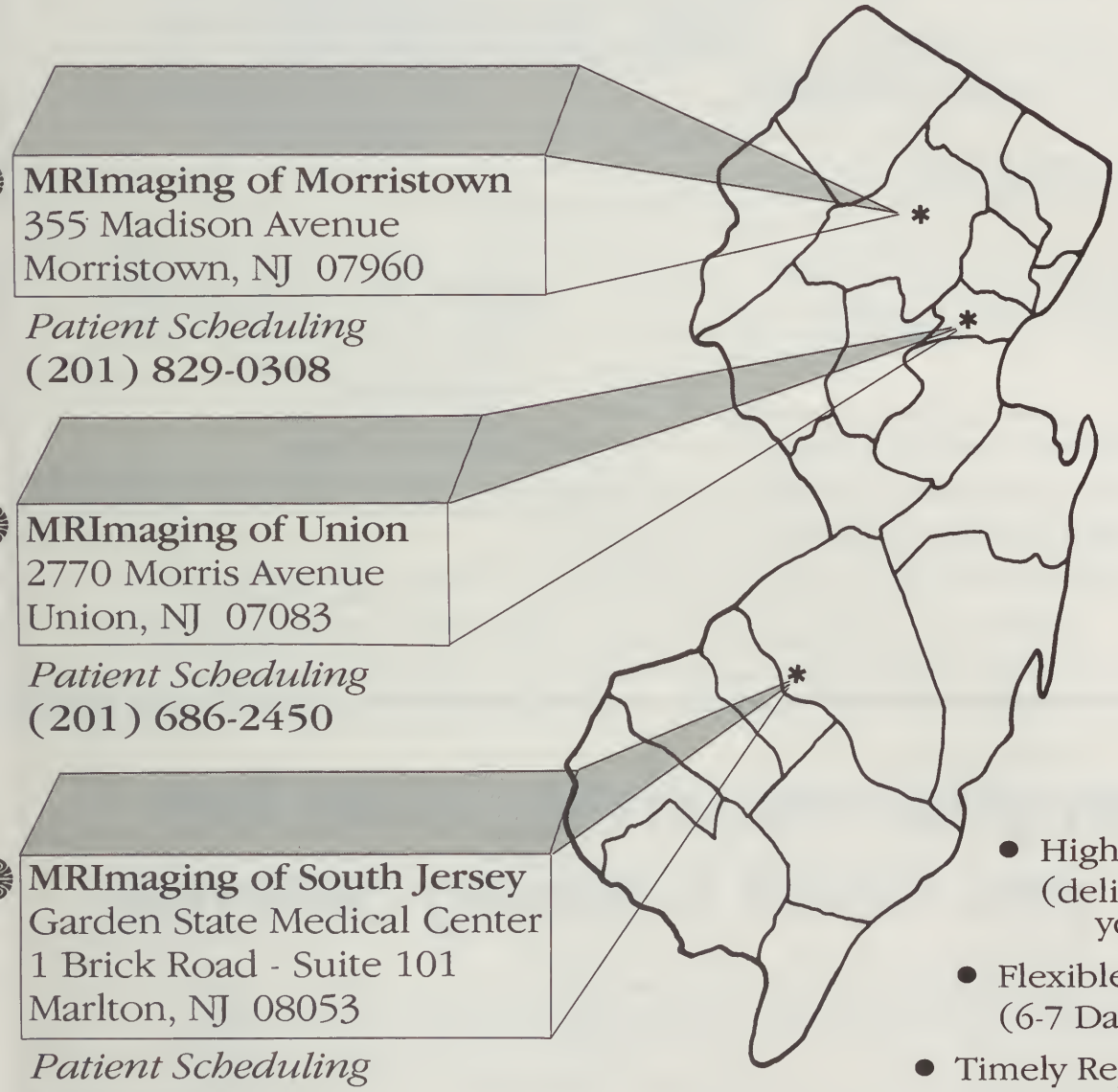
Kathleen Voldish, CLA (ASCP), is available to present a program to physicians entitled "How To Prepare Your Physician Office Laboratory for CLIA-88 Regulations." The one-hour program can be presented by calling 609/428-8414.

The controversy over the upcoming Clinical Laboratory Improvement Act Amendments (CLIA-88) continues. CLIA-88 will federally regulate all physician office laboratories. Numerous comments were received by the Health Care Financing Administration (HCFA) concerning the expansion of Level I tests, relaxing the physician director requirements in Level II, and linking the personnel requirements to test complexity in Level II.

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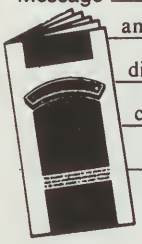
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EDITOR'S DESK

VITA BREVIS

How relevant is Hippocrates (5th century B.C.) to the modern world, its physicians, and its patients? In this issue of *NEW JERSEY MEDICINE* we have two articles, one relating to the oath and the other to the aphorisms of Hippocrates.

The body of literature ascribed to Hippocrates undoubtedly includes writings from other authors in the eastern Mediterranean world, has had various and varied translations and interpretations, and constitutes at least 72 books and 59 treatises.

This issue's articles point out areas of relevance. Yet, in 1822, Thomas Coar wrote in his preface to a translation of the Aphorisms:

> "Amongst these Aphorisms it must be confessed, however, there does occasionally appear one which is trifling, or even somewhat absurd; so unworthy indeed of the mind of Hippocrates, and so inconsistent with the general style and vigor of his conclusions, that we are fully authorized to term them spurious, and to ascribe them to those frivolous beings who aimed at distinction by mingling their own follies with the wisdom of others which they could not imitate.

Let me offer you a sample of the potential spurious:

- Aphorism II, 20—"They who in youth have relaxed bowels, in old age become constipated. But they who in youth are constipated, in advanced life have the bowels relaxed."

Couple this with:

- Aphorism II, 53—"They who during youth have open bowels, are more easily freed from disease than those who are constipated; in advanced life however it is otherwise, for the bowels are then commonly more confined."

And decide whether they derive from the same source.

- Aphorism IV, 41—"Copious sweating during sleep, without a manifest cause, indicates that too much food has been used; but denotes, if food has not been taken, that evacuations are required."

It seems we may have overlooked a simple, nonhormonal cure for the nocturnal sweats noted by many menopausal women.

Let us also examine certain areas in the oath from a relevancy point of view:

- "To teach them this art if they so desire without fee or written promise."

Even if we were to be extremely liberal in compensating for expenses, can the tuition costs in some of today's CME programs be justified? It seems that newer technologies bring an associated "the sky's the limit" philosophy with them. Should not our certifying Boards and our Colleges

become more active in assuring both proper credentialing and compensation as we enter a post-junk bond decade?

- "To please no one will I prescribe a deadly drug, nor give advice which may cause his death."

Today's therapeutic armamentarium encompasses many "deadly drugs," with safe ranges impinging on toxic ones, particularly when used in combination with other medications. The knowledge of drug actions and interactions, therefore, is of increasing importance to the practitioner of the 1990s.

And, we can easily reconcile "pulling the plug" activities with "nor give advice which may cause his death." Relieving suffering, that may hasten the pronouncement of death, but which does not "cause" death is a well-accepted principle across the land. It is more difficult for many to accept the active euthanasia attitudes of the Hemlock Society and of physicians in a small northern European country.

- "Nor will I give a woman a pessary to procure abortion."

This represents one of today's dilemmas. In Hippocrates's day, the stricture may have been less a matter of morality than of good medicine, abortion being attended by extremely high morbidity and mortality.

Notwithstanding all of the above, the opinions of the two authors in this issue are valid. As with all articles we publish, they should stimulate the reader to view them critically and, we hope, to be encouraged to pursue collateral readings. Hippocrates was truly the Father of Medicine. He freed it from the influences of the priesthood, firmly based on superstition, and substituted bedside observation and experience with the entire patient, not just with disease, and used this accumulated data to promote the teaching and perpetuation of the art and science of our noble profession. He enriched the nobility of our discipline by adding ethics and morality to art and science. He is a man for all ages.

> "Vita brevis; ars longa; occasio celeris; experimentum periculosum; judicium difficile."
>
> "Life is short; art is long; opportunity fugitive; experience delusive; judgment difficult." Aphorism I, 1. □

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Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalmic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

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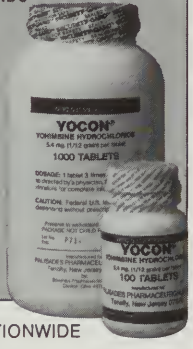
Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

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References:

1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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BOOK REVIEWS

THE A-Z OF WOMEN'S SEXUALITY

Ada P. Kahn and Linda Hughey Holt, MD. New York, NY, Facts on File, Inc., 1990. There are several problems with this book. The text is presented as a dictionary of terms and persons having to do in some way with sex, but doesn't everything? The authors define amor lesbicus (an obsolete term for lesbianism) and give a biographical paragraph of Clara Thompson (an American psychoanalyst), yet such a compendium can be found in any dictionary or basic psychology text. The book lacks direction and focus, and worst of all—it makes sex uninteresting. I do not recommend this book for anyone. □ G.F. Hansen, MD, MPH

DIAGNOSIS AND THERAPY OF SYSTEMIC FUNGAL INFECTIONS

K Holmberg and RC Meyer (eds). New York, NY, Raven Press, 1989. This text reflects the interest in the area of clinical fungal disorders in the growing numbers of immunocompromised patients, e.g. AIDS, who when treated with other antibiotics may secondarily become infected with these organisms. In addition, the numbers of patients receiving other forms of immunosuppressive reagents for underlying malignancies appear to increase annually, bringing the issue of infection with these relatively hard to treat organisms to the forefront of the practicing physician's mind. Over the past ten years, the quantum leap forward in immunological and molecular biological techniques has reopened the opportunities to reexamine the diagnosis and the earlier initiation of therapy in these life-threatening disorders. The text alone superficially covers this topic by a limited cadre of authors with a small number of typographical errors, e.g. the diagnostic use of IgG (sic) in allergic bronchopulmonary aspergillosis should actually be "IgE levels." I can only recommend the purchase of this book with reservations by anyone interested. There are several other better texts covering the same topic that presently are available. □ Leonard Bielory, MD

INTERNATIONAL PERSPECTIVES IN EXERCISE PHYSIOLOGY

Krystyna Nazar, MD, Ronald L. Terjung, PhD, Hanna Kaciuba-Uscilko, PhD. Champaign, IL, Human Kinetics Books, 1989. The internist or cardiologist interested in sports medicine will find some useful information in this volume of the proceedings of the International Symposium on Exercise Physiology held in Sandomierski, Poland. Among the topics of interest are cardiovascular adjustments and adaption to physical exercise metabolism and performance, thermoregulation responses, and a discussion on factors determining endurance performance. This book is a good reference for the physician interested in sports medicine research. □ Christine E. Haycock, MD

MANUAL OF LABORATORY IMMUNOLOGY

LE Miller, PhD, HR Ludke, JE Peacock, RH Tomar, MD. Philadelphia, PA, Lea & Febiger, 1990. This softcovered text is an extensive "manual" falling between the spectrum of two other recent texts, *Practical Immunology* (Blackwell) and *The Manual of Clinical Laboratory Immunology* (American Society of Microbiology). This book contains a tremendous amount of information on the various immunological techniques and their uses in technical evaluation of the most common clinical assays ordered by the clinician. The book briefly covers an overview of immunology, specimen preparation and handling, and interpretation of

statistics (sensitivity, specificity, and predictive value). The text then dedicates chapters to assays assessing lymphocyte quantification and function; immunoglobulins; complement; other serum proteins including C reactive protein, haptoglobin, alpha 1 antitrypsin and the cytokines; and phagocytes. In addition, there is information on the expansive literature on infectious agents with chapters solely dedicated to viral, bacterial, fungal, and protozoal infections. Each chapter ends with details on how the tests are performed, the caveats, and the interpretation of the results that are extremely informative and helpful for the everyday physician interested in this area. ☐ Leonard Bielory, MD

MEDICAL MICROBIOLOGY SYNOPSIS

DM McClean and JA Smith (eds). Philadelphia, PA, Lea & Febiger, 1990. This softcovered text truly lives up to its name as a synopsis of the tremendous amount of information available on the expansive literature on infectious agents. The text has assimilated the required clinical information of the various infectious agents that are being reclassified into a simple introduction, morphology, culture characteristics, classification, pathogenesis and pathology, and clinical features and treatment. The text also includes information on the expanding realm of antiinfective agents and succinctly summarizes the newly developed thirdgeneration cephalosporins, monobactams, iminipenems, and antifungals. The text is organized in a similar fashion to the more expansive texts of microbiology, but I would highly recommend this one for the clinician who always is consulting infectious disease experts for simple problems. The text covers this topic in a helpful manner for the everyday clinician to keep up to date. ☐ Leonard Bielory, MD

PEDIATRIC NEUROIMAGING

A. James Barkovich, MD. New York, NY, Raven Press, 1990. While magnetic resonance imaging (MRI) has evolved into the standard imaging modality of neuroradiology, a solid review of its applications to the pediatric population has been absent from the medical literature. This text fills that void, offering a concise yet thorough synthesis of state-of-the-art techniques and interpretations of pediatric neuroradiology. MR receives the heaviest emphasis, but computed tomography (CT) scanning also is explored. The first chapter offers an overview of the technical aspects of pediatric imaging such as sedation, contrast agents, and scanning parameters. The clinically oriented sections incorporate a comprehensive discussion of developmental brain imaging, metabolic diseases, congenital malformations, neoplasms, hydrocephalus, and spine imaging. This timely publication is a consistently readable treatise with high-grade quality scans to match. It deserves a place on the bookshelf of the interested physician. ☐ Neil B. Horner, MD

SPORTS INJURIES: DIAGNOSIS AND MANAGEMENT

James G. Garrick, MD, and David R. Webb, MD. WB Saunders, Philadelphia, PA, 1990. This comprehensive guide to athletic injuries and their management belongs on the shelf of any physician dealing with athletes. By "comprehensive" I do not mean that every possible injury to an athlete is included, but those that are (the most frequent ones) receive thorough coverage of diagnosis, treatment, and rehabilitation. The first two chapters describe a professional approach to the history and physical examination of the injured athlete including reasonable and necessary diagnostic tests. The succeeding chapters discuss various injuries by types, i.e. overuse, acute, or anatomical location. The book is well written and profusely illustrated; it is a valuable reference even for the experienced physician. I found the rehabilitation section particularly educational. The text concludes with a chapter on decision analysis, laying out an algorithm particularly valuable to the sports medicine researcher. ☐ Christine E. Haycock, MD

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LETTERS & VIEWPOINTS

SQUAMOUS CELL CANCER OF THE LARYNX

While the case history in the report, "Squamous Cell Cancer of the Larynx in an Intravenous Drug User with AIDS" (87:811-812, 1990), is an interesting footnote, it does not suggest that this patient with AIDS had cancer of the larynx due to immunosuppression. While it is true that the age for cancer of the larynx peaks over 50 years old, case reports in individuals as young as 11 years old are known in the literature. It is not an infrequent cancer in patients between 30 and 50 years old. □
Stephen F. Freifeld, MD

AUTHOR RESPONSE

Dr. Freifeld is correct in suggesting that the relationship between AIDS and squamous cell cancer is not established. However, there is a definite increase in secondary malignancies in patients with AIDS. We believe physicians should consider the possibility of HIV infection when a patient at risk for the disease presents with an unusual malignancy. □
Joseph G. Barone, MD

LIVING WILLS

The United States Supreme Court decision about Nancy Cruzan creates an intense interest in living wills. Living wills are advanced statements about one's wishes in the event of a terminal illness. At the time of writing a living will, it is logical to designate someone who can act in one's best interest in the event of incapacity.

While the court did not explicitly decide on the significance of a living will, it was evident that without a living will, there was no "clear and convincing" evidence of Nancy's desires. Therefore, the parents could not make health care decisions for her.

The heightened interest in living wills and designated surrogate decision makers has value, as a frame of reference. There is the danger, however, that it could divert interest away from addressing some of the deficiencies present in decision making at the bedside.

Henry Wadsworth Longfellow underscores our ambiguity concerning death with the following poem:

As a fond mother, when the day is o'er,
Leads by the hand her little child to bed,
Half willing, half reluctant to be led,
And leave his broken playthings on the floor;
Still gazing at them through the open door,
Not wholly reassured and comforted
By promises of others in their stead,
Which though more splendid, may not please him more;
So nature deals with us, and takes away
Our playthings one by one, and by the hand
Leads us to rest so gently that we go
Scarce knowing if we wish to go or stay,
Being too full of sleep to understand
How far the unknown transcends what we know.

Where is the source of courage and compassion necessary to confront

the ambiguity central to the dying process? Who in the health profession can be a "fond mother" for suffering patients? The results of our medical advances are awesome. The technologic imperative impacts on us in ways that are subtle and profound. What person in their right mind would reject the benefits! Therefore, we create the belief, transformed into legal language, that for anyone to be uncertain about future treatment reflects error in one's thinking, and only "clear and convincing evidence" expressed through living wills ought to be the basis for treatment termination.

In the process of mastering high technology medicine, doctors are distanced from the bedside. For generations, our mentors, the medical professors, absorbed by research and charged with the responsibility to transfer the mountain of scientific material to the student, were denied direct responsibility for the total care of the dying patient. Inexperienced in this art, physicians suffer from an atrophy of disuse. The technology coming between the patient and the doctor, masks their mutual ambivalence, uncertainties, and vulnerabilities. Therefore, instead of walking "into the shadow of death" and "leading by the hand her little child" we physicians promise more technologies, more "playtoys."

There are ways to improve physicians' beneficent parenting, and still prevent the evils of paternalism. There are models of good and "fond mothers" from whom we can learn.

It would be well for those persons responsible for the well being of patients and the public to write living wills. For me, it was a most sobering and anxiety-producing experience; for I am daily reminded of the technology-driven environment and gestalt into which my desires would be weighed and quite possibly ignored! There is little way in which we can reflect on the reality of our own death.

Fortunately, the medical profession is becoming increasingly aware of its shortcomings. In pursuit of dialogue, we are observing examples of exquisite compassion. We observe the neonatology nurse comforting the child, born at grave risk, attached to the "broken playthings," the death prolonging technologies. The nurse at once comforts the doctors, the parents, and even the parents' parents! Likewise, the nurse in attendance, be it critical care, nursing home, or hospice, has not lost the awareness of one's own vulnerability, and, hence, rather than become a piece of the instrument, becomes, like St. Francis an "instrument of Thy peace."

Nurses, social workers, and pastoral caregivers are some who can identify through lenses cleansed by tears of compassion what the Supreme Court calls "clear and convincing" evidence!

Some of us have conducted extensive interviews with nurses who have ministered to patients like Nancy Jobes and Karen Ann Quinlan (patients in permanent coma, some of whom have had feeding tubes removed). They have uniformly stated their willingness to nurse patients. As one nurse stated, "It is the privilege of our calling to be present at the time of birth and the time of death, including the cessation of artificial food and hydration and other medical technologies."

There are limits to what any court can do to make these decisions more tolerable. It behooves us to confront our own uncertainties and to create effective processes for shared decision making. By so doing, we will reestablish the bridge of trust and accountability that are the fundamental foundations of the healing profession. □ Joseph Fennelly, MD

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The Abiding Validity of the Hippocratic Oath

MARK D. FOX

Physicians, ethicists, and other medicine-watchers make frequent references to the "Hippocratic tradition" in discussions of medical ethics. This tradition, they often assert, has shaped the central commitments and obligations of physicians since antiquity and continues to do so today. Rarely, however, do they offer a definite characterization of this tradition. The Hippocratic precept: "First to help, or at least to do no harm"[1] represents the common understanding of the Hippocratic tradition. While this precept stands as the keystone of the contemporary understanding of the Hippocratic tradition, it is the Hippocratic oath that serves as the vehicle for the profession of the physician's commitment. Interestingly, the precept that represents the Hippocratic tradition does not even appear in the oath; it comes instead from a later Hippocratic document, though its fundamental sentiment is at least implicit in the oath. Thus, the oath provides the foundation for the ongoing tradition and also serves as the vehicle for the transmission of that tradition. The question remains, however, whether the oath is appropriate to the contemporary understanding of the physician's responsibilities.

The Hippocratic oath was composed 2,500 years ago as a manifesto for physicians of the ascetic Pythagorean sect. Some physicians contend this document grew out of a world view totally foreign to our own and, thus, is inappropriate as an expression of contemporary medicine's fundamental obligations.[2] As evidence, they cite the swearing of the oath before Apollo and all the gods and goddesses. Furthermore, the oath's proposed model of medical education, regarding your teacher's family as your own, does not fit with modern experience. Perhaps the most significant objection that can be raised, however, is simply the fact that the oath never was intended to profess the commitments and obligations of all physicians. The oath was written for a very specific, and very ascetic, sect. The strict prohibitions of the oath reflect the philosophical and ethical commitments of the Pythagoreans.[3] The prohibition against surgery is consistent with their emphasis on dietetics; likewise, their prohibitions against abortion and suicide reflect their belief that life begins at conception and their commitment to uphold and preserve the sanctity of life. Clearly, the world view of the author (or authors) of the Hippocratic oath is quite removed from our 20th-century experience. In addition, the specific content of the oath is largely at odds with contemporary medical practice and thought. Nevertheless, many medical school graduates continue to profess the oath, and the Hippocratic tradition is upheld as an ideal. In fact, the classicist and medical historian Ludwig Edelstein sees in the oath the paradigm for all subsequent reflection on medical ethics.[3] Why, we may ask, is an oath, so foreign to the contemporary practice of medicine, still treasured and regarded as the foundation for medical ethics?

One may argue, not incoherently, that the oath stands as a traditional symbol of an ancient profession. The contemporary utterings of the oath symbolize the tradition in which the oath-taker stands. In his essay on the medical covenant, AMA Executive Vice-President James S. Todd, MD, suggests that in the oath, the physician assumes certain duties and obligations in exchange for the support

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and latitude that society accords to physicians.[4] Although the terms "profession" and "vocation" had not yet been applied to the practice of medicine at the time of the oath's composition, the oath signals the foundation for the emergence of the professional identity of the physician. Thus, the oath today symbolizes that professional identity, rather than constituting a commitment to its specific terms. Others may see certain specific commitments in the oath as central to the fulfillment of the physician's vocation, even today. For example, Dr. Lafrance suggests, in response to Dr. Collier, that "the firm commitment in favour of life," that he contends is central to the oath, is as relevant today as it was at the time of the oath's composition.[5] Dr. Todd, on the other hand, sees the oath as "a philosophical allegory for promising to practice with faith in science and new knowledge."[4] In that regard, the oath pledges to apply "measures for the benefit of the sick according to my ability and judgment."[4] The oath then, in Dr. Todd's view, provides the vehicle whereby physicians include ethical provisions in their covenant with society. Each of these positions ascribes value to the oath, either as symbol, covenant, or specific commitment to the sanctity of life.

UMDNJ President Stanley Bergen, MD, and Cheryl Tice of UMDNJ assert, "The meaning of the Hippocratic oath changes with the times, social conditions, and medical knowledge," but the oath "provides flexibility of interpretation and adaptation to changing times and conditions, allowing it to retain its validity."[6] However, while the oath has been subject to a variety of interpretations through the ages, none of these positions accurately specifies what accounts for the abiding validity of the oath.

The Hippocratic oath is a remarkable document in terms of its role as the faint beginnings of the professional identity and vocation of the physician; also remarkable is its longevity as the paradigm for medical ethics. And yet few have come to appreciate the fundamental moral insight of the oath that accounts for its abiding validity as a statement of the physician's moral commitment. The significant insight of the oath is its recognition of the fundamental asymmetry of the relationship between the physician and the patient.[7] The oath calls for responsibility on the part of physicians in light of the considerable power they possess in relation to a vulnerable and disadvantaged patient.[8]

An individual, the patient, presents to the physician with an illness or injury. In such a condition, the patient is fundamentally compromised, at a disadvantage. Furthermore, the patient presents to one whose profession is to heal, one who has the knowledge and experience necessary to restore the patient to health. The physician has knowledge that the patient lacks and which the patient requires to be made whole again. In the course of this clinical relationship, the physician, who may well be a stranger to the patient, encounters the patient in the most intimate of ways. The physician has access to the patient's life, history, family, and body in extraordinary ways, while the patient does not have the same access to the physician. Furthermore, this asymmetry and the physician's power and status in this relationship are sanctioned by various social institutions and professional organizations. The oath recognizes this fundamental asymmetry; in response, the oath acknowledges an obligation inherent in the practice of medicine to respect the patient and to be sensitive to the risks and vulnerability which the patient experiences. The oath's admonitions against sexual misconduct and all kinds of mischief, as well as its respect for the confidentiality of the relationship, grow out of this view of the moral nature of the physician-patient relationship.

The recognition of this asymmetry and the subsequent commitment to moral sensitivity regarding the relationship between the physician and patient constitute the fundamental moral insight of the Hippocratic oath. Further, it is this insight that provides the foundation for the subsequent Hippocratic tradition and ensures its abiding validity for contemporary medicine. The oath stands as the physician's moral resolve with respect to this asymmetric relationship: both as a personal vow or dedication, and also a commitment to patients and society. Regardless of how the face of medicine has changed or will change, the moral resolve professed in the oath constitutes its abiding validity. ■

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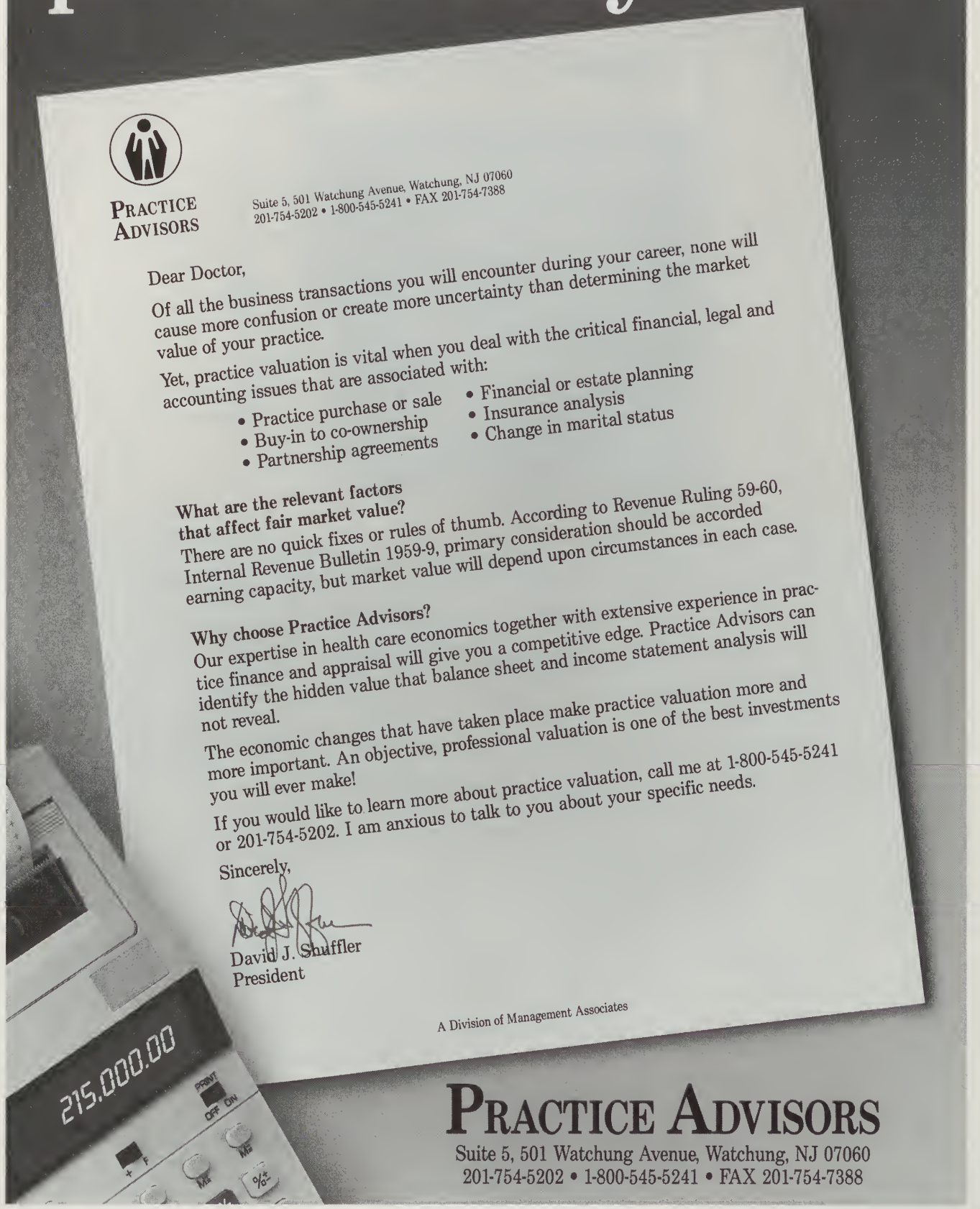
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Aphorisms of Hippocrates

MORRIS SOLED, MD

The following is a sampler of aphorisms by Hippocrates (circa 460-375 B.C.) of Cos.

No victuals ought to be given, or forced upon such as have fits returning periodically. But food ought to be rather diminished before manifest tokens appear to judge of the disease.[1]

Author's note: Treatment of epilepsy with starvation or fatty diet so as to cause mild acidosis was mentioned in my time at medical school (ketogenic diet), 2,400 years later.

If in a disease sleep brings labour and pain, it is a mortal sign: but if ease and mitigation of pain, it is a good sign.[1]

Author's note: If a patient with peritonitis or pleurisy falls asleep and his breathing consequently becomes deeper, the change is more likely to cause pain from deeper excursion of the diaphragm transmitted to the abdominal viscera, hence "labour and pain." If the sleep brings healing rest without increased pain, the patient was not ill with diffuse peritonitis and, therefore, more likely to survive. The inflammation is more likely localized away from the diaphragm.

If he has pneumonia, the upper surface of the diaphragm and adjacent pleura are less likely to be involved. This author well remembers his pleuritic pain of lower lobe pneumonia at age ten, before penicillin, and its interference with sleep.

Those who have gripings in the belly, and violent pain about the navel and the loins, which cannot be removed by purging medicines, nor any other means, will fall into a dry dropsy.[1]

Author's note: A dry dropsy refers to tympanitic distention. The above text is expecting that the onset of intestinal obstruction with severe peristalsis (violent pain) will lead to an ileus with distention. A laxative will not relieve the obstruction.

Those who have their sides swelled and a murmuring in their guts, succeeded by a pain in the loins, shall have a looseness except they break wind, or void a great quantity of urine. These things happen in fevers.[1]

Author's note: This may be a description of the insidious onset of Bright's disease, with oliguria and flank distention (fluid retention), followed by aching in the renal area ("pain in the loins") generally attributed to renal swelling and consequent painful stretching of the renal capsule.

If the patient's condition worsens, uremia ensues with uremic colitis and diarrhea ("a looseness"). If the patient recovers, bowel function continues ("they break wind") without diarrhea as the transient uremia subsides and diuresis follows the oliguric stage ("void a great quantity of urine").

The nephritis may follow a febrile illness by 7 to 20 days (such as poststreptococcal glomerulonephritis). Although nephritis is afebrile in our textbook, Hippocrates mentioned that "fevers" are a part of the illness without being specific as to when. Perhaps he saw lingering febrile sore throats.

A further subtlety in differential diagnosis is the mention of "murmuring in their guts" as concurrent with the flank swelling, so that the bowel motion is noted to be continuing ("murmuring"), occurring with another process outside the bowel. The oliguria causing the flank swelling is earlier than the pain in the loins when the kidneys later swell enough to stretch the renal capsule.

The diarrhea follows as uremia supervenes in those who are not yet recovering. The persistence of bowel sounds and flatulence (as opposed to diarrhea), and arrival of diuresis, harbingers of escape from uremia, portend a favorable outcome in a composed sequence of bedside observations.

CONCLUSION

Clinicians who take pride in their powers of observation can still benefit from analytical art in description by Hippocrates. ■

Dr. Soled is a member of our Committee on Publication.

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CVP Catheter in Thoracentesis

DAVID C. HON, MD
LUISA GUENA, MD
JAMES E. BARONE, MD

Since the classical method of thoracentesis was described,[1] modifications have been made.[2-4] The most significant change was the use of a plastic intravenous catheter unit.

We describe a procedure in which a single-lumen central venous pressure (CVP) catheter is used for the evacuation of pleural effusion. The technique eliminates the possibility of catheter shearing and breaking when the catheter is pulled back against the needle. It is a safer method and as simple and efficient in evacuating pleural effusion.

TECHNIQUE

The patient is placed in a sitting position at the bedside, leaning forward with arms supported on a bedside table. If the patient is unable to sit upright, the supine position with the head of the bed raised to 90° also can be assumed.

After reviewing the chest x-ray, the level of fluid in the pleural space is confirmed by percussion. The level of thoracentesis then should be planned at one or two interspaces below the percussed fluid level in the posterior axillary line. It should not be lower than the 8th interspace counting upward from the 12th rib posteriorly and 2nd rib anteriorly.

The skin is prepared with povidone-iodine and drapes should be placed around the area of thoracentesis. Using sterile technique, 1 percent xylocaine is infiltrated into the skin over the middle of the rib below the intercostal space selected. Anesthetic is injected into the deeper tissues by "walking" up the rib over its superior aspect, aspirating during the process.

A 18-gauge needle from the CVP kit then is attached to a 10 cc syringe. The needle is inserted over the anesthesized area of the rib "walking" up to the superior margin of the rib into the pleural space. During this time, the syringe is aspirated continuously. Entry into the pleural space is confirmed by fluid return into the syringe. The depth of the needle is marked with a clamp (Figure 1). The syringe then is removed and the lumen of the needle occluded. A J-tip guidewire is inserted into the lumen of the needle to about twice the length of the 18-gauge needle (Figure 2). The needle is removed, leaving only the guidewire in the pleural space (Figure 3). A small incision is placed over the puncture site of the needle in order to facilitate entrance of the 16-gauge single-lumen CVP catheter. The dilator usually is not needed. In an obese patient, it can be inserted over the guidewire into the pleural space to a depth not greater than the initial needle puncture marked with a sterile clamp (Figure 4).

After placement of the CVP catheter over the guidewire, the wire is removed and the placement of the catheter confirmed by aspirating with a 10 cc syringe. A three-way stopcock is attached between the CVP catheter and a 50 cc syringe. The other arm

The paper was submitted in June 1990 and accepted in July 1990. Requests for reprints may be addressed to Dr. Barone, St. Francis Medical Center, 601 Hamilton Avenue, Trenton, NJ 08629.

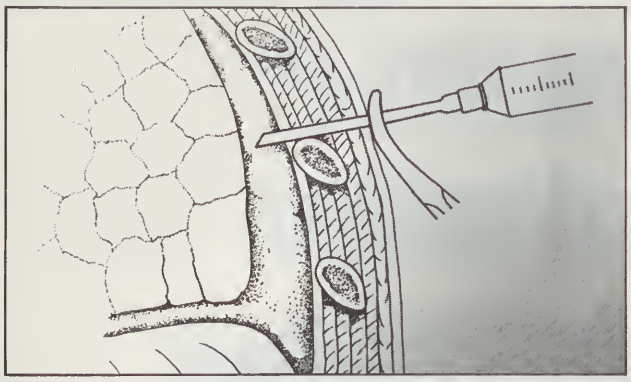


Figure 1. Insertion of thoracentesis needle with attached syringe to appropriate depth indicated by a flow of fluid into syringe. Depth of needle marked by Kelly clamp.

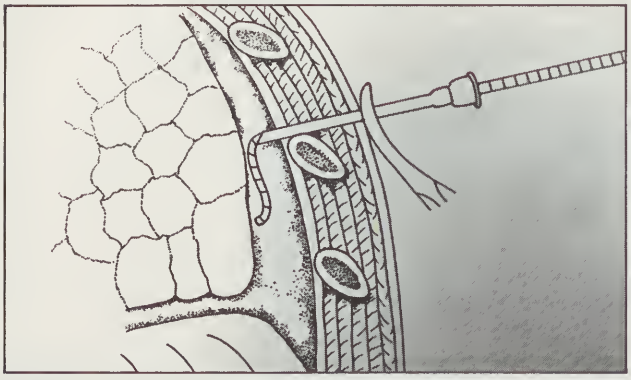


Figure 2. Syringe is removed and J-tip guidewire is inserted through the needle into pleural space.

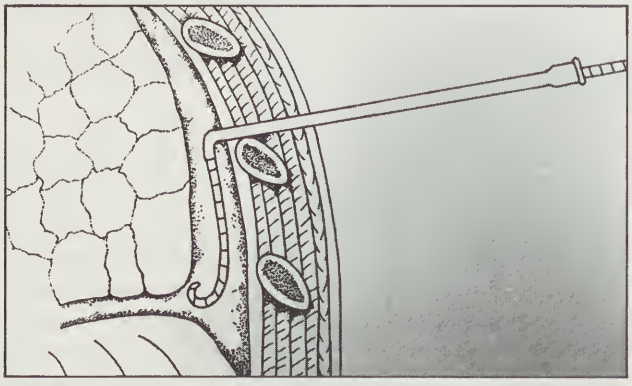


Figure 3. Needle is removed leaving guidewire in place.

of the stopcock is attached to a sterile container. Fluid can be aspirated into the syringe with a stopcock "off" to the container and then turning the stopcock "off" to the CVP catheter to evacuate the fluid from the syringe into the container. If a large vacuum bottle is used, fluid can be aspirated by turning the stopcock "off" to the syringe and open to the vacuum bottle (Figure 5).

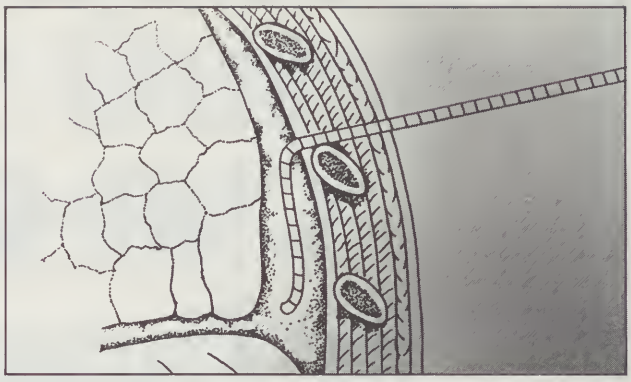


Figure 4. Catheter is introduced into pleural space via guidewire.

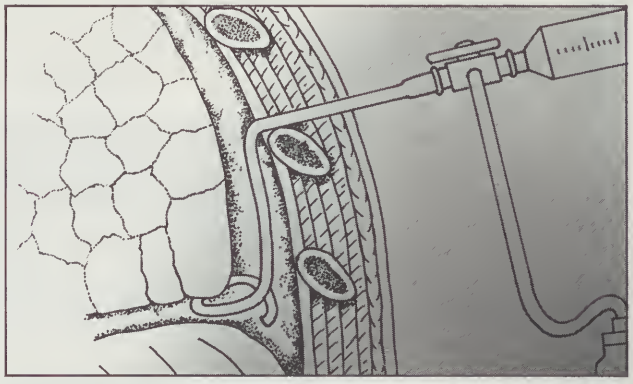


Figure 5. Catheter is connected to three-way stopcock, syringe, and Foley bag or to sterile vacuum bottle to evacuate pleural fluid.

After aspiration of the pleural effusion, the CVP catheter is removed and a sterile dressing applied over a small piece of petrolatum gauze. A chest x-ray subsequently is obtained to confirm evacuation of the pleural effusion and to check for a pneumothorax.

DISCUSSION

Thoracentesis can aid in the diagnosis of the disease process through analysis of the fluid recovered. The quantity of effusion removed should not exceed 1,000 cc to 1,500 cc as unilateral pulmonary edema, hypotension, and severe chest pain can result.[5]

The use of a single-lumen CVP catheter is a safe, simple, and convenient means of evacuating pleural effusion. It is less likely to cause a pneumothorax than a needle and is less painful and less restrictive than placement of a chest tube. Because of its position in the pleural space, a more complete evacuation of the effusion can be accomplished. It also can be used as a means of introducing sclerosing agents for malignant pleural effusion. ■

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Pulmonary Edema

due to Extreme Left Atrial Compression

ANTHONY DELUCA, MD
STEVEN DANIELS, MD
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Pulmonary edema is a common concomitant of valvular heart disease and ventricular dysfunction. In addition, left atrial dysfunction due to thrombus, myxoma, or cor triatriatum can produce the same clinical picture. We encountered a patient with intractable pulmonary edema secondary to obliteration of the left atrial cavity by an extrinsically compressing lung tumor. We believe extrinsic compression of the left atrium caused impaired left atrial filling, leading to pulmonary venous hypertension and pulmonary edema.

The causes of cardiogenic pulmonary edema are manifold, related to systolic or diastolic ventricular dysfunction, arrhythmias, pericardial disease, valvulopathies, or left atrial thrombus, tumor, or cor triatriatum. We report a case of cardiogenic pulmonary edema resulting from left atrial compression by bronchogenic carcinoma with near complete obliteration of the left atrial cavity and subsequent impairment of left atrial filling.

CASE REPORT

A 59-year-old black female with a history of carcinoma of the lung, diagnosed eight months prior to admission, presented with a left hip fracture sustained in a fall at home. She also complained of dyspnea, orthopnea, and pedal edema for the last two months.

Her past medical history was significant for a history of adenocarcinoma of the lung, diagnosed by mediastinoscopy in April 1986, that was treated with radiotherapy. There was no history of rheumatic fever, congenital heart disease, myocardial infarction, systemic hypertension, or pericarditis. There was a long history of tobacco use.

Physical examination revealed a cachectic female in mild to moderate respiratory distress. Blood pressure was 120/80 mm Hg without pulsus paradoxus. The pulse was 140/min. The respiratory rate was 32/min. Her temperature 98.8°F. The neck veins were not distended. Carotid upstrokes were normal. Cardiac examination revealed a right ventricular lift. There was a normal S_1, and S_2 was accentuated. There were no murmurs, rubs, or gallops. There were diminished breath sounds at the right base and rales were noted in the lower half of both lung fields. There was digital clubbing and +2 pitting edema of

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the lower extremities. Peripheral pulses were equal bilaterally and graded 2/4.

Hemoglobin was 11.5 g; hematocrit was 35%. White blood cell count was 14,500 with 83% segmented forms, 16% lymphocytes, and 3% monocytes. Arterial blood gases obtained while the patient was breathing room air revealed a pH of 7.54, $PaCO_2$ 37 mm Hg, PaO_2 41 mm Hg, oxygen saturation of 83.4%, and serum bicarbonate level of 31 meq/L. A chest x-ray displayed cardiomegaly, a left hilar mass, right basilar atelectasis, and pulmonary vascular congestion. The electrocardiogram demonstrated atrial flutter with 2:1 AV response and nonspecific ST-T wave abnormalities.

A two-dimensional echocardiogram was performed using a #77020AC Hewlett-Packard cardiac ultrasound machine with a 25 MHz transducer. It demonstrated severe compression of the left atrium by an extrinsic, well-circumscribed mass. The left atrial cavity was almost completely obliterated, but the left atrial wall was smooth with no suggestion of tumor invasion (Figure). The left ventricular dimensions and function were normal, as were all valvular structures. The main pulmonary artery was enlarged, although the pulmonic valve was not notched and an A wave was present. The right atrium and ventricle were normal in diameter. Cardiac catheterization was not performed because of the patient's terminal status. The patient was treated with intravenous furosemide with partial response, but remained in refractory congestive heart failure. The patient was discharged approximately one month after admission and subsequently expired. A postmortem examination was refused.

DISCUSSION

A patient with bronchogenic carcinoma developed pulmonary edema and was found to have severe extrinsic compression of the left atrium by the tumor. We postulate that this patient had impaired left atrial filling as a result of the left atrial compression resulting in pulmonary venous hypertension and pulmonary edema.

Neoplastic compression of cardiac structures previously has been documented by two-dimensional echocardiography. A case similar to ours was reported by Kinney involving immunoblastic lymphoma causing compression of the left atrium and

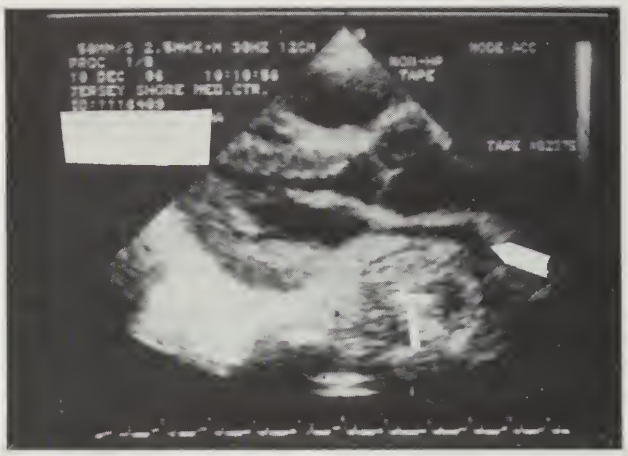


Figure. Two-dimensional echocardiography: left parasternal view, long axis (T = tumor; arrow = large mass causing compression of left atrium).

pulmonary veins without evidence of pulmonary edema.[1] Popovic and associates reported the ability to detect left atrial invasion by tumor with the use of two-dimensional echocardiography.[2] Right ventricular outflow obstruction by mediastinal tumors also has been demonstrated by echocardiography.[3]

Pulmonary edema resulting from pulmonary venous hypertension may be the result of pulmonary veno-occlusive disease[4] or a result of left atrial hypertension due to ventricular dysfunction pericardial disease, aortic and mitral valvular disease or left atrial obstruction by tumor, thrombus, or cor triatriatum.[5] Our patient did not have evidence of myocardial, pericardial, or valvular heart disease by echocardiography and was not shown to have an intracardiac mass.

Although pulmonary veno-occlusive disease cannot be completely excluded, we believe this rare disorder was unlikely since usually it affects children and young adults.

We have demonstrated left atrial compression by a large bronchogenic tumor by echocardiography, without evidence of actual invasion of the left atrium by this tumor. Although neoplastic left atrial compression previously has been documented, resultant pulmonary edema has not been described. We believe the bronchogenic carcinoma caused pulmonary edema by severe extrinsic compression of the left atrium leading to impaired left atrial filling from the pulmonary veins and subsequent pulmonary venous hypertension. ■

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Pleural Effusions in AIDS

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BENJAMIN H. SAFIRSTEIN, MD

The authors present clinical, radiographic, and laboratory findings, and the results of therapy for 16 patients with pleural disease and HIV infection. The study underscores the wide variety of etiologies of pleural effusions and recommends a stepwise pragmatic approach in evaluating such patients, making no distinction between non-HIV-infected subjects.

The human immunodeficiency virus (HIV) affects virtually every organ system in the human body. With the exception of pleural disease, pulmonary manifestations have been well described.[1-2]

In acquired immunodeficiency syndrome (AIDS), the lungs are one of the most commonly involved organ systems, reported to occur in 41 percent of patients. Respiratory problems most commonly suggest the diagnosis of AIDS, with *Pneumocystis carinii* pneumonia (PCP) accounting for more than 50 percent of initial presentations.[3-4] While infiltrates on chest radiograph are compatible with the diagnosis of PCP, pleural effusions rarely are seen and are suggestive of other disease.[2]

The authors describe the clinical presentation and results of investigating the pleural effusions in 16 HIV-positive patients.

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METHODS

The authors retrospectively reviewed the 1988 medical records from Saint Michael's Medical Center of 16 HIV-positive patients presenting with pleural effusions. For each of the 16 patients with pleural effusions, we recorded the following: age and sex, AIDS versus AIDS-related complex (ARC), utilizing Centers for Disease Control (CDC) surveillance criteria; risk factors; clinical and radiographic presentation; reactivity to purified protein derivative (PPD); peripheral hemoglobin, leukocyte count with differential, lactate dehydrogenase (LDH), alkaline phosphotase, total protein, albumin, and arterial blood gas levels; pleural total protein, leukocyte count with differential, LDH, glucose, and pH; blood and pleural culture results; and pleural biopsy results.

Pleural effusions were divided into transudate or exudate and the overall incidence was calculated as the number of patients with pleural effusion divided

Table 1. ***Infiltrates; number of patients with findings.***

Location	Number of Patients	Incidence
Right lower lobe	6/16	38%
Left lower lobe	4/16	25%
Right/left upper lobe	3/16	19%
Right middle lobe	1/16	6%
Bilateral	1/16	6%

Table 2. ***Distribution of pleural effusion.***

Location	Number of Patients	Incidence
Right sided	8/16	50%
Left sided	5/16	30%
Bilateral	3/16	20%

Table 3. ***Peripheral blood laboratory data.***

	ARC	AIDS
White blood cell count (10 3)	14	7.3
Percent lymphocytes	10	24
Hemoglobin (g/dL)	11.5	10
Total protein (g/dL)	6.7	6.9
Albumin (g/dL)	2.6	2.9
Lactate dehydrogenase (IU/L)	334	331
Alkaline phosphotase (IU/L)	70	135
Pa O_2	75	69
Pa CO_2	30	33

by the total number of HIV-positive patients evaluated by the pulmonary division for HIV-related respiratory disease.

RESULTS

Incidence and Epidemiology. Pleural effusion occurred in 16 of 120 HIV-positive patients for an overall incidence of 14 percent. The average age was 35 years and there were 12 males and 4 females. Eight patients had AIDS and 8 patients had ARC by CDC criteria. Of the patients in our study, 12 patients were intravenous drug addicts (IVDA) and 4 patients were homosexuals.

Clinical Presentation and Laboratory Data. All 16 patients presented with fever and cough; 13 patients had chest pain; 11 patients had weight loss; 4 patients had night sweats; and 1 patient had diarrhea. There was no statistical difference of presenting symptoms between the AIDS and ARC patients. Pulmonary infiltrates occurred in 15 of 16 patients (Table 1). Other findings included cavitary nodules, bilateral cysts, and hydropneumothorax, each occurring in 1 patient. Two patients had cardiomegaly. Location of pleural effusions (Table 2), average values of peripheral blood data (Table 3), and pleural fluid data comparing empyema to parapneumonic effusions (Table 4) are presented. Seven patients had positive blood cultures. Four patients

had *Staphylococcus aureus,* 2 patients had group A B-hemolytic *Streptococcus* and 1 patient had both *Staphylococcus aureus* and group A B-hemolytic *Streptococcus.* Of the 8 patients with right-sided effusion, 5 patients had ARC and 3 patients had AIDS. Four of the 5 AIDS patients had left-sided effusions. Four pleural biopsies were performed and revealed nonspecific inflammation in 2 patients: granuloma and poorly differentiated epidermoid carcinoma. The patient who had granulomas on pleural biopsy had *Mycobacterium tuberculosis* on sputum culture. There were two positive pleural fluid culture results: *Staphylococcus aureus* and *Cryptococcus neoformans;* both patients were intravenous drug addicts.

Table 4. ***Pleural fluid analysis.***

	Empyema		Parapneumonic	
	ARC	AIDS	ARC	AIDS
Total protein (g/dL)	6.0	5.0	2.0	4.8
Lactate dehydrogenase (IU/L)	2608	539	358	180
Glucose (g/dL)	39.5	68.3	126	97
White blood cell count	1830	598	1644	871
Percent lymphocytes	75	8	59.5	60.3
pH	6.9	7.1	7.4	7.4

Table 5. ***Final diagnosis of pleural effusion.***

	ARC	AIDS
Empyema	2	4
Parapneumonia	3	3
Transudates	2	0
Tuberculosis	1	0
Malignancy	0	1

DISCUSSION

The lungs are one of the most commonly involved organ systems in AIDS. Radiographic infiltrates often lead to a diagnosis of PCP. Pneumonia, lymphocytic interstitial pneumonitis (LIP), tuberculosis, and mediastinal lymphadenopathy due to lymphoma, have been well described in AIDS patients.

Pleural effusions, however, rarely are seen and suggest complications associated with AIDS. Sixteen patients are described presenting with documented pleural effusions of diverse etiology. Only 2 patients had tuberculosis that ultimately responded to chemotherapy. Six patients had empyemas documented on blood and pleural fluid culture. In 2 patients, empyema was the first clinical manifestation of HIV-related disease and prompted serologic studies. In the remaining 4 patients, empyema was but one more complication of AIDS. Five of the 6 patients with empyema were effectively treated with appropriate antibiotics and drainage. Parapneumonic effusions were seen in 6 patients and occurred as part of a community-acquired pneumonia. All responded to antibiotic therapy.

Pleural space infections can be clearly expected in patients with impaired immunologic surveillance;[6-9] however, we encountered a 32-year-old male with AIDS who presented with a primary pulmonary malignancy, a finding most unexpected and, to our knowledge, not previously described.[9-10]

Lastly, two patients had transudative pleural effusions associated with cardiac enlargement attributed to HIV-associated cardiomyopathy.[11]

Pleural effusions in patients with HIV-related disease are due to infections, neoplasms, and cardiac disorders. Such patients should be evaluated thoroughly as they respond in most instances to standard regimens. The variety of etiologies necessitates a pragmatic and stepwise analysis of fluid and pleural tissue. ■

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Gastric Hemorrhage and Kaposi's Sarcoma

Treated with Radiotherapy

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V.S. VENKATASESHAN, MD
THOMAS W. KIERNAN, MD

A 66-year-old man, with advanced alcoholic liver disease with Kaposi's sarcoma involving the stomach and the skin of the lower extremities, developed upper gastrointestinal hemorrhage. He was treated with radiation therapy to the stomach and the skin with rapid resolution of the gastric lesions, as demonstrated by serial endoscopy.

Multiple idiopathic pigmented sarcoma, known as Kaposi's sarcoma, occurs commonly in the skin, as well as in the internal organs.[1] Involvement of the gastrointestinal tract has been reported with varying frequency,[2] most often as asymptomatic submucosal and mucosal lesions found endoscopically or at autopsy.[3]

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Current treatment includes radiotherapy to the involved extremity and various chemotherapeutic regimens directed toward lesions of the internal organs.[2,4,5] We report the occurrence of gastric hemorrhage due to Kaposi's sarcoma in a patient with alcoholic cirrhosis, involving the stomach and the skin of the lower extremities, treated successfully with radiotherapy.

CASE REPORT

A 66-year-old white man, of Irish descent, was admitted for ascites and jaundice, with a long history of chronic ethanol consumption. There was no history of homosexuality or drug abuse. The clinical



Figure 1. Characteristic lesions of Kaposi's sarcoma, with macular and nodular lesions and brawny edema of the lower extremity.

history included a vague sensation of dysphagia of six months' duration that was nonprogressive, and periodic swelling of the legs for over a year. On examination, the patient had excoriated, purplish macules and occasional nodules on the feet and lower legs with brawny edema below the calf (Figure 1). The liver measured 10 cm at the midclavicular line, and was firm and nontender. Splenic tip was palpable. No other abdominal masses were felt. The laboratory examination revealed: hemoglobin 11 gm/dL with macrocytosis and target cells; total white cell count 7,400/cmm with normal differential count; SGOT 63 U/L (N = 0-41 U/L), total serum bilirubin 4.0 mg/dL (N = 0.2-1.2 mg/dL); direct

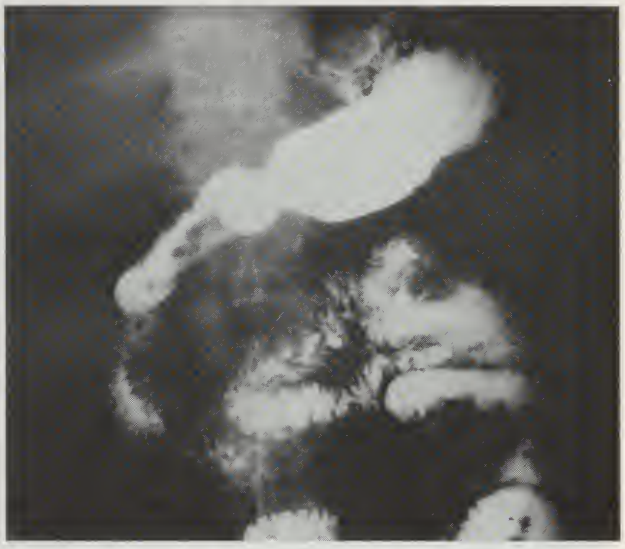


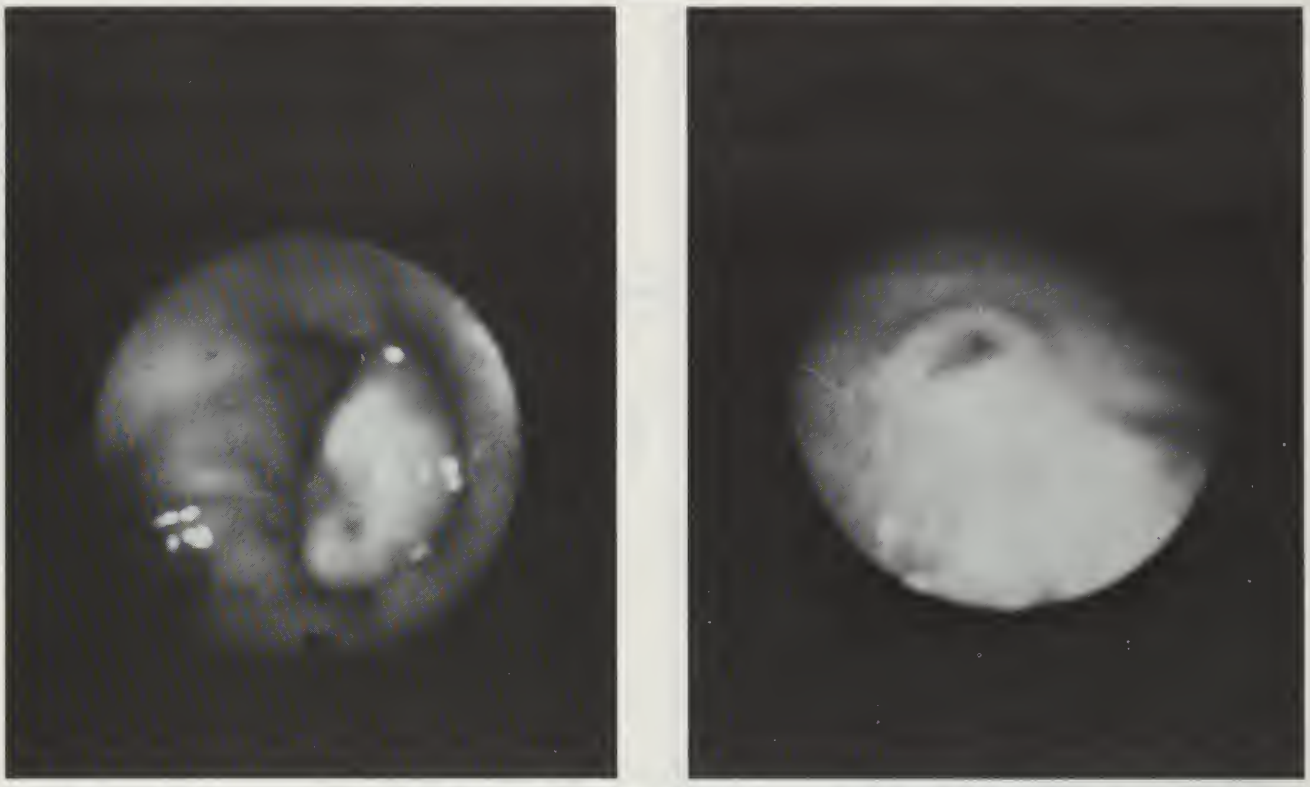
Figure 2. Upper gastrointestinal series showing multiple irregular defects in the antral wall with compression and a smooth outline of the rest of the stomach.

bilirubin 2.4 mg/dL (N-O-0.3 mg/dL); albumin 2.7 g/dL (N = 3.0-5.5 g/dL); alkaline phosphatase 221 U/L (N-30-115 U/L). Antibody titers to cytomegalovirus and Epstein-Barr virus were not significantly elevated. Skin tests for PPD, *Candida,* and mumps were negative. Abdominal paracentesis yielded clear yellow fluid with a cell count of 500 cells/mm^3, mostly lymphocytes, total protein of 1.2 g/dL and a specific gravity of 1.012. Culture and cytologic examinations were negative.

With these patient findings, we made an initial diagnosis of Kaposi's sarcoma of the skin of the lower extremities and decompensated alcoholic liver disease.

An upper gastrointestinal series demonstrated large antral folds in an otherwise normal stomach. Esophagogastroduodenoscopy revealed a normal esophagus, mild diffuse erythema of the gastric and antral mucosa, and a solitary, smooth nodular lesion of the antrum that on biopsy showed only chronic inflammation. At the same time, biopsies of the skin lesions in the lower extremity were obtained, demonstrating bundles of spindle-shaped cells and vascular slits containing red blood cells, characteristic of Kaposi's sarcoma. A course of radiotherapy was given to the lower extremities (3,000 rads over six weeks) with some improvement. During his hospital

We note that early (symptomatic and asymptomatic) visceral lesions along with cutaneous lesions in Kaposi's sarcoma can be treated by radiotherapy alone with almost complete resolution.



Figures 3A and 3B. Endoscopic appearance of nodular and ulcerated (volcano) Kaposi's lesions in the stomach; eight nodular lesions, covered by mucosa, ranged in size from 0.7 to 1.2 cm in diameter.

stay, jaundice resolved and ascites responded gradually to diuretics.

Three months later, the patient was readmitted for local surgical debridement of the skin lesions. The lower extremity lesions were hyperpigmented, macular, and edematous, but less nodular. The abdomen was distended because of recurrent ascites. While in the hospital, he experienced a sudden bout of upper gastrointestinal hemorrhage with a drop of blood pressure to 90/60 mmHg, and a pulse rate of 120 beats/min. Rectal examination revealed melena but no masses. An upper gastrointestinal series showed a smooth stomach lining; with compression, multiple irregular defects in the antral wall were noted (Figure 2). No abnormalities were found in the small intestine. Endoscopy demonstrated eight nodular lesions, covered by mucosa along the lesser curvature of the gastric antrum, some with ulceration, and blood clots on the surface (volcano-type lesions) ranging in size from 0.7 to 1.2 cm in diameter (Figures 3A and 3B). No evidence of esophageal varices was noted. Following stabilization of the acute bleeding, repeat endoscopy and a biopsy showed these lesions had features characteristic of Kaposi's sarcoma (Figure 4). Colonoscopy disclosed no abnormalities. A CT scan of the abdomen showed only ascitic fluid. Laparoscopy revealed a small, nodular liver and a biopsy confirmed the presence of micronodular cirrhosis. Because of the concern over the toxic effect of chemotherapeutic agents in a patient with advanced liver disease, radiotherapy (external beam radiation using cobalt) was chosen as a mode of treatment and administered to the stomach (3000 rads over six weeks). The patient was maintained on a sodium-restricted diet and diuretics and discharged.

Gastroscopy performed one month after the completion of the course of radiation demonstrated a remarkable resolution of the volcano-type lesions and the polypoid lesions in the antral region, leaving only one small nonulcerated nodule measuring 0.4 cm and erythematous mucosa. During this hospitalization, the patient underwent hepatic vein catheterization confirming the presence of portal hypertension. No abnormalities were observed in the stomach during a second followup endoscopy, three months later. The patient presented with dehydration, hyponatremia, ascites, and vomiting 18 months after initial admission. He expired two weeks later due to massive gastrointestinal bleeding.

DISCUSSION

Diagnostic problems are known to arise during the development of earlier stages of Kaposi's lesions, and it is possible that the initial biopsies of the single gastric nodule taken from our patient may represent an early lesion. Endoscopy over a period of three months showed rapid development of the gastric lesions with formation of maculopapular, polypoid, and ulcerated nodular (volcano) lesions.

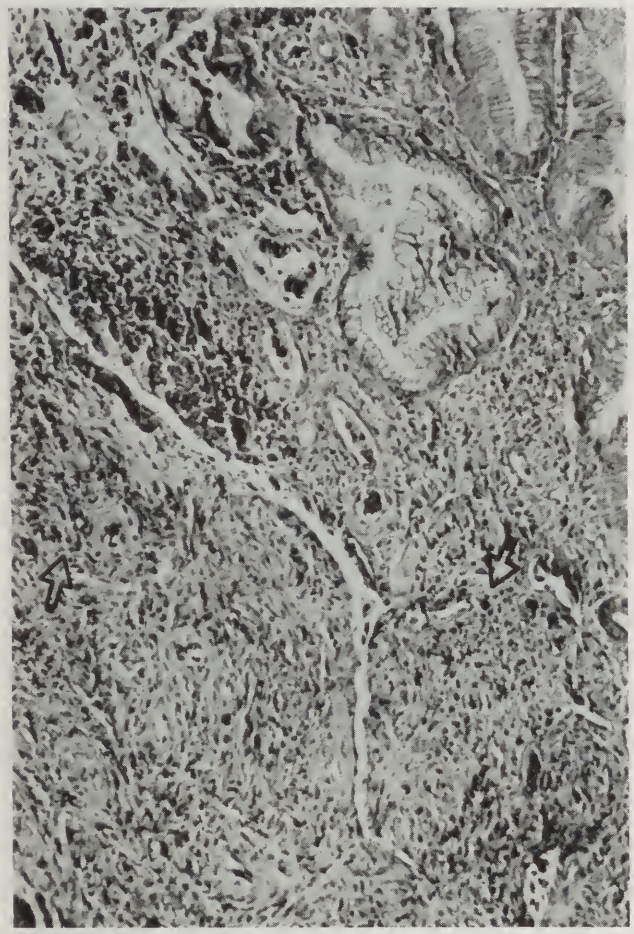


Figure 4. Gastric mucosa showing bundles of spindle cells forming vascular slits, some containing red blood cells (arrows), typical of Kaposi's sarcoma (hematoxylin & eosin x 160).

Both the skin and stomach were treated with 3,000 rads over six weeks. While there was partial response of the skin lesions, total resolution of gastric lesions was noted during followup endoscopy, one and three months later.

Literature contains detailed descriptions of cases of Kaposi's sarcoma in the population of Africa, notably Uganda and the Congo Basin,[6,7] seen frequently in young, male black patients. Female patients constitute 10 percent of cases, and often tend to have a more aggressive or generalized form of the disease.[8] A more indolent European-American form, mainly limited to the skin of the extremities, occurs sporadically in the elderly population, predominantly in males. The disease runs a course of 8 to 13 years, and death generally occurs from other causes. Silent visceral involvement has been reported in most cases with nodular disease, the gastrointestinal tract being the most common site.[8] Ahmed suggested the need for endoscopic evaluation of patients with Kaposi's sarcoma because of the higher incidence of otherwise unsuspected visceral lesions.[2] The massive gastrointestinal hemorrhage secondary to Kaposi's sarcoma noted in our patient is not common and may have been initiated by preexisting portal hypertension.

The incidence of Kaposi's sarcoma is known to be higher in patients with immunologic abnormalities,[9] in immunosuppressed patients,[10] in organ transplant recipients,[11] and in AIDS or ARC patients.[3] Our patient had no evidence of AIDS or drug abuse (other than alcohol), received no immunosuppressive therapy, and had no demonstrable lymphoproliferative disorder or other malignancies. Patients with alcoholic cirrhosis also may have varying degrees of immunocompromised states.[12] We believe that the liver disease may have contributed to the atypically rapid evolution of the gastric lesions seen in our patient, perhaps due to altered immunologic status in cirrhotic patients or by obstruction of the portal circulation.

While various chemotherapeutic agents have been used with good success in the visceral lesions,[2,5] we note that early (symptomatic and asymptomatic) visceral lesions along with cutaneous lesions in Kaposi's sarcoma also can be treated by radiotherapy alone with almost complete resolution. This modality is useful in those patients with chronic liver or kidney disease who cannot tolerate chemotherapy. ■

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Nodular Intraperitoneal Masses

in a Patient with Cirrhosis

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DANIEL D'AURIA, MD

The authors present differentiation of varices from adenopathy by duplex ultrasonography with discussion of ectopic intraperitoneal varices.

Our patient is a 32-year-old female with a history of chronic active hepatitis and resultant postnecrotic cirrhosis, diagnosed in 1973. Because of the autoimmune etiology, she was treated with immunosuppressant therapy and has been on maintenance therapy with oral prednisolone. Recent developments of mild encephalopathy and fluid retention required regular use of lactulose and diuretics. The cirrhotic liver is not palpable, but the spleen is prominently enlarged. Despite this, the patient has lived a rather normal and productive life: she is married and works full time. There is no history of melena or hematemesis.

In January 1990, she was admitted to the hospital with diarrhea, abdominal cramping, and worsening encephalopathy. A computed tomography (CT) scan revealed splenomegaly and multiple nodular densities in the region of the splenic hilus (Figure 1) and multiple nodular densities present in the retroperitoneum (Figure 2).

Dr. Jacoby is acting director, Department of Diagnostic Radiology and Nuclear Medicine, and Dr. D'Auria is a fellow in gastroenterology, Cooper Hospital/University Medical Center. This paper was submitted in June 1990 and accepted for publication in August 1990. Requests for reprints may be addressed to Dr. Jacoby, Cooper Hospital/University Medical Center, One Cooper Plaza, Camden, NJ 08103.

DISCUSSION

This patient has obvious clinical and radiographic signs of portal hypertension and cirrhosis including diminution in the size of the liver with marked splenomegaly. Multiple nodular densities identified in the intraperitoneal space, but particularly in the region of the splenic hilus, create a dilemma in differentiating adenopathy from varices.

CT with intravenous contrast enhancement has been shown to be useful in distinguishing lymph nodes from varices. However, it has been demonstrated that greater than normal doses of contrast may be needed to diagnose varices because of the blood volume in these collaterals, and the subsequent dilution of intravenous contrast.

Ultrasonography can demonstrate these large collateral vascular channels; however, their hypoechoic or anechoic nature may simulate the appearance seen with lymphomas (Figures 3A and 3B). Interrogation of these masses by doppler imaging clearly demonstrates the presence of low venous flow indicating their vascular nature.

The incidence of ectopic varices occurring in patients with portal hypertension is difficult to assess since unless they bleed, they may go unrecognized. It is established, however, that the prevalance of bleeding ectopic varices is more common with ex-

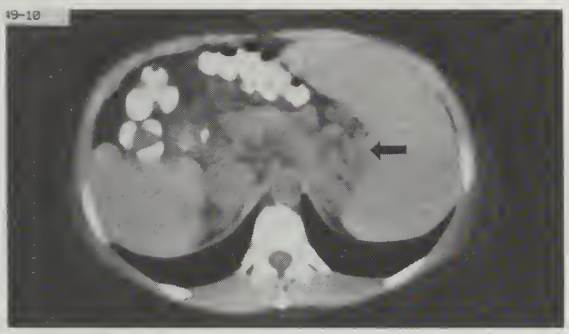


Figure 1. CT scan through upper abdomen demonstrating marked splenomegaly with multiple nodular densities (arrow) in the region of the splenic hilum.

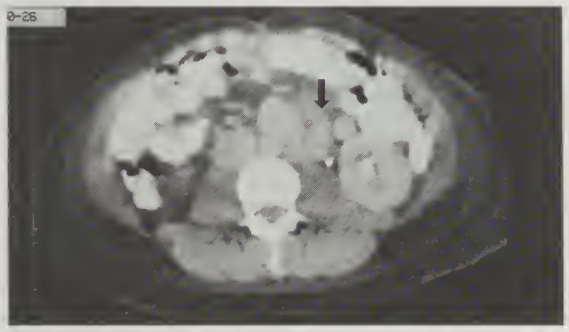


Figure 2. CT scan through lower third of abdomen demonstrating multiple nodular densities in the para-aortic region (arrow).

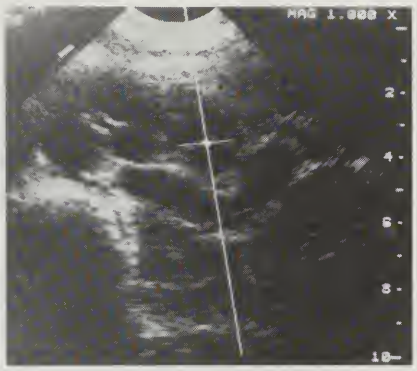


Figure 3A. Transverse ultrasonography in the region of the splenic hilum demonstrating multiple hypoechoic nodular densities. Cursor is indicating point of sampling for doppler interrogation.

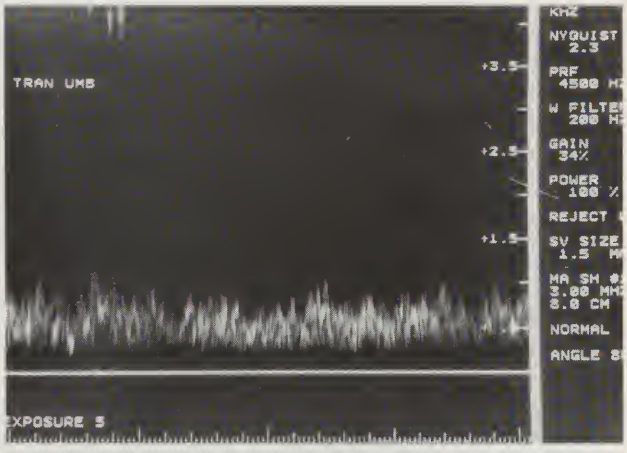


Figure 3B. Doppler wave form demonstrates a continuous low frequency wave form compatible with venous flow indicating the vascular nature of these nodular abnormalities.

trahepatic portal hypertension (20 to 30 percent) than with intrahepatic portal hypertension (1 to 3 percent). In addition, the incidence of bleeding ectopic varices markedly increases in patients with portal hypertension who have had preceding abdominal or pelvic surgery.

Approximately one-third of bleeding ectopic varices occur in the duodenum resulting from anastomoses of the afferent branches of the portal vein to the superior mesenteric vein through the duodenal and retroduodenal venous channels.

In extrahepatic portal hypertension, these varices may result in portal-portal anastomoses through the splenic, gastroepiploic, and superior mesenteric veins. Varices in this location very frequently coexist with esophageal varices, that may cause confusion as to the site of origin of the bleeding. Barium contrast studies, endoscopy, and arteriography are helpful in further evaluating these patients.

In contradistinction to duodenal varices, jejunoileal bleeding varices generally are not related to portal hypertension. This group comprises one-third of all patients with ectopic varices and most frequently are associated with prior abdominal or pelvic surgery causing collaterals to form through postoperative adhesions between the jejunum, ileum, and abdominal wall. These patients frequently present with melena without hematemesis.

Approximately 25 percent of patients with bleeding ectopic varices present with colonic varices and 50 percent of those patients are in the region of the sigmoid colon. This location generally is associated with cirrhosis and intrahepatic portal hypertension and may present with massive melena.

Only 10 percent of patients with bleeding ectopic varices present with an intraperitoneal location, as in this patient. When these varices rupture, dramatic manifestations of sudden abdominal pain, abdominal distention, tachycardia, and hypotension may occur. The bleeding often is massive and may be fatal. CT and duplex ultrasonography may be of great value in differentiating bleeding varices from bleeding hepatocellular carcinoma that is much more common in such patients' cirrhosis.

Diagnosis: Ectopic intraperitoneal varices secondary to intrahepatic portal hypertension. ■

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The Use of Mannitol

in Intracerebral Bleeds in the Medical ICU

CHRISTINE M. GIGLIUTO, MD
KEVIN E. STONE, MD
MICHAEL ALGUS, MD

To determine the effects of mannitol osmotherapy, we reviewed patients admitted to the intensive care unit with a presumptive diagnosis of increased intracranial pressure. The conclusion from our 20-patient study revealed no significant therapeutic benefit using mannitol osmotherapy.

The management of increased intracranial pressure (ICP) in intracerebral bleeds (ICB) or thrombotic strokes has been a relatively unstudied subject. Most studies have been cited in the neurosurgical literature. These studies usually were performed in the setting of head trauma. The use of mannitol in raised ICP due to intracerebral hemorrhage (ICH) or stroke is acknowledged to be empiric.[2] Mannitol, hyperventilation, and steroids commonly are used to treat increased ICP in the medical intensive care units (ICU), without the use of invasive monitoring. Patients with raised ICP from medical ICB and thrombotic stroke have a high morbidity and mortality. The purpose of this retrospective study is to evaluate the overall risk-benefit ratio, complications, and improvement in patients with presumptive increased ICP secondary to ICB and thrombotic stroke when treated with mannitol.

Drs. Gigliuto, Stone, and Algus are affiliated with the Department of Medicine, Jersey City Medical Center, Jersey City. The paper was submitted in April 1990 and accepted in July 1990. Requests for reprints may be addressed to Dr. Gigliuto, 2126 Apollo Street, Apt. 9B, Ocean, NJ 07712.

METHODS

We retrospectively reviewed all patients with a presumptive diagnosis of raised ICP due to either massive ICB or large thrombotic stroke admitted to the medical ICU over a three-year period, 1986 to 1989, at Jersey City Medical Center. The diagnosis of raised ICP was made largely on the basis of clinical grounds, i.e. changing mental status with pupillary signs, evidence of decerebrate/decorticate

Table 1. ***Clinical characteristics of subjects.****

	Controls	Mannitol Subjects
Number	10	10
Age Range	37-85	42-76
Average Age	64	56
Female:Male	6.4	5.5
Intracerebral Bleed by CT Scan	8	10
Thrombotic Stroke	2	0
Glascow Coma Scale at Presentation	3-12	3-12
Average Glascow at Presentation	8.1	6.4
Glascow Coma Scale After Treatment	3.14	3.12
Average Glascow After Treatment	6.5	5.1

*Average values computed by adding respective values divided by ten—the number of subjects.

posturing, or rapidly changing hemodynamics in the setting of presumed ICB. For incorporation into this study, patients had subsequent evidence of mass effect seen on computed tomography (CT) scan, large ventricular bleed, or documented clinical signs of herniation. Entry data for use in this study included patients with an admitting diagnosis of either ICH or large thrombotic stroke, with medical treatment including osmotherapy often initiated prior to CT scan confirmation on clinical suspicion alone (Table 1). Patients were excluded from this review if there was evidence of trauma, preceding ICB before hospital admission, evidence of subarachnoid or subdural bleeds, or evidence of preceding meningitis. In addition, patients were not included in this study if their stay in the medical ICU did not equal at least one day, or if they had died in the emergency room.

Patients' charts were reviewed citing the following criteria: age, sex, race, and diagnosis before therapy was begun. Ages ranged from 37 to 85 years with a total of ten men and ten women distributed between both the control and mannitol-treated groups. Charts were examined reviewing the patients' electrolytes before and after osmotherapy, as well as the development of complications; mortality data were accrued. Physical examination on admission and either at death, if the event occurred within four days or within 48 hours after osmotherapy was begun, were retrospectively examined calculating the Glascow Coma Scale. Patients were examined by the following criteria: Glascow Coma Scale before and after therapy, hypotension development after therapy, and diabetes insipidus with the development of dehydration after therapy. The diagnosis of diabetes insipidus was made in our patients by calculating the maximum inputs over a 24-hour period, that period occurring within two days of the use of osmotherapy. This diagnosis was made retrospectively if the patient excreted greater than five liters of fluid daily, without previously recorded high outputs of fluid prior to the use of osmotherapy,[8] or within 48 hours of admission in subjects in which mannitol was not used as osmotherapy. In addition, patients' electrolytes were reviewed, specifically examining the serum sodium, potassium, and serum osmolarity before and after therapy. The serum osmolarity was a calculated value using the formula: (2 x serum sodium) + BUN/1.8 + glucose/18. Statistical analysis was performed using dBase 4 database management on an IBM Ps2/70 personal computer and a Sharp EL-520 scientific calculator. Statistical analysis was performed by an independent consultant.

RESULTS

We evaluated 20 charts. Eighteen of these 20 patients had a diagnosed ICB by CT scan and the remaining 2 patients had evidence of thrombotic cerebrovascular accident (CVA). Ten patients had the use of mannitol incorporated in their treatment; of these 10 patients, 7 patients had high-dose mannitol used in a dosage of 1 g/kg and the remaining 3 patients had low-dose mannitol used in a dosage of 0.25 g/kg. None of the 10 control patients received mannitol; however, 2 control patients had low-dose furosemide used in a dosage of 40 mg daily. Other modalities used included hyperventilation in 9 out of 10 mannitol subjects and in 4 out of 10 controls. Steroids were used in 7 out of 10 mannitol subjects and 7 out of 10 controls.

A total of 50 percent of the patients in which osmotherapy was used showed an increase in serum sodium by at least 5 MEqu versus an increase of 5 MEqu seen in only two of the control patients. This 50 percent was distributed as 57 percent of the high-dose patients and 33 percent of the low-dose patients. A decrease in serum sodium by at least 5

MEqu was seen in 30 percent of the mannitol subjects, while this was noted in only 10 percent of the control subjects. We did not notice an increase in serum potassium with the use of high-dose mannitol as previously had been reported.[7] An increase in serum osmolarity of at least 5 mOsm was seen in 60 percent of the mannitol group as well as 50 percent of the control subjects. It has been suggested that an increase of a minimum of 10 mOsm in serum osmolarity is correlated with a decrease in intracranial pressure.[2] Of our ten mannitol subjects, four subjects of the high-dose group and one subject of the low-dose group had at least a 10 mOsm increase in serum osmolarity with three of these patients having a serum osmolarity greater than 315 mOsm after the use of mannitol. (Calculated serum osmolarities were 363, 334, and 360, respectively in these subjects.)

In terms of statistical analysis, the following figures were arrived at:

1. The average difference in serum osmolarity in the control patients not receiving mannitol within 48 hours was 19.1 mOsm/L.

2. The average difference in serum osmolarity in all patients who received mannitol was 20.1 mOsm/L. This included an average serum osmolarity difference of 33.5 mOsm/L in those patients in whom high-dose mannitol was used and an increase in serum osmolarity was seen.

3. Confidence interval about mean of treated patients: $x = 20.2 \pm 19.2$ or $1.0 < x < 39.4$. Confidence interval about mean of untreated patients: $x = 19.1 \pm 21.8$ or $-2.7 < x < 40.9$. The difference between the control group and the patients in which mannitol osmotherapy produced a rise in serum osmolarity was not statistically significant at $P = -.1$.

In terms of complications, a greater incidence of diabetes insipidus was noted in the patients in which mannitol was used. Twenty-nine percent of the patients in which high-dose mannitol was used and 33 percent of the patients in which low-dose mannitol was used developed diabetes insipidus subsequent to the start of osmotherapy; only 10 percent of the controls developed diabetes insipidus. Hypotension was noted to occur in 20 percent of the high-dose mannitol group and 66 percent of the low-dose mannitol group for a total of 40 percent of patients given osmotherapy, in contrast with the development of hypotension in 30 percent of the control subjects.

In terms of neurologic improvement via the Glascow Coma Scale, four patients in each group demonstrated no change. One patient in each group showed signs of improvement with one-half of each group having a decreased Glascow Coma Scale. An overall 70 percent mortality rate was recorded in the mannitol subjects and an 80 percent mortality rate was shown in the control subjects (Tables 2, 3, 4).

We also analyzed whether these observed neurologic changes could be correlated to changes in serum osmolarity. The average initial Glascow Coma Scale score of all patients with increases of at least 5 mOsm/L in serum osmolarity was 5.2 contrasted with a followup score of 4.0. Thus, increased serum osmolarity does not appear to be associated with improved neurologic status. Of the mannitol-treated patients showing an increased serum os-

Table 2. ***Changes observed in electrolytes.***

	Sodium Increase by 5		Sodium Decrease by 5		Potassium Increase by 5		Serum Osmolarity Increase by 5	
	No.	Percent	No.	Percent	No.	Percent	No.	Percent
Mannitol								
High Dose	4/7	57	3/7	43	0/7		5/7	71
Low Dose	1/3	33	0/3	—	2/3	67	1/3	33
Total	5/10	50	3/10	30	2/10	20	6/10	60
Controls	2/10	20	1/10	10	4/10	40	5/10	50

Table 3. ***Incidence of complications.***

	Diabetes Insipidus		Seizures		Hypotension	
	No.	Percent	No.	Percent	No.	Percent
Mannitol						
High Dose	2/7	29	1/7	14	2/10	20
Low Dose	1/3	33	1/3	33	2/3	66
Totals	3/10	30	2/10	20	4/10	40
Controls	1/10	10	4/10	40	3/10	30

Table 4. ***Changes in neurologic status.***

	No Change		Decreased Glascow		Improvement in Glascow		Mortality	
	No.	Percent	No.	Percent	No.	Percent	No.	Percent
Mannitol								
High Dose	3/7	43	3/7	43	1/7	14	5/7	71
Low Dose	1/3	33	2/3	66	—	—	2/3	66
Totals	4/10	40	5/10	50	1/10	10	7/10	70
Controls	4/10	40	5/10	50	1/10	10	8/10	80

molarity of at least 5 mOsm/L, the difference between the final and initial Glascow Coma Scale score was: x= -1.5 (s=4.8, n=6). Of the control patients having an increased serum osmolarity of at least 5 mOsm/L, the difference between the final and initial score was: x= -2.2 (s=2.5, n=5). Here a positive value would imply improvement, whereas a negative value would imply a worsening condition. Thus, mannitol-treated patients do not appear to respond better than untreated controls in this study, in terms of neurologic improvement as judged by the Glascow Coma Scale.

CONCLUSION

Mannitol is an osmotic diuretic that elevates blood plasma osmolarity resulting in enhanced flow of water from tissues including the brain and cerebrospinal fluid (CSF), into interstitial fluid and plasma. As a result, cerebral edema, elevated ICP, CSF volume, and ICP may be reduced.[4,5] Mannitol is not without its recognized side effects that include cardiopulmonary functional impairment secondary to the sudden expansion of the extracellular fluid compartment leading to congestive heart failure; electrolyte imbalances including hyponatremia, hyperkalemia, hypovolemia with hypernatremia, and the development of diabetes insipidus; renal function impairment; and potential drug interactions with digitalis and furosemide as well as extravasation of mannitol during its infusion leading to skin necrosis.[6]

In this study, we have not demonstrated a significant therapeutic response with the use of mannitol in ICB in the medical ICU. Morbidity, mortality, and Glascow Coma Scale virtually were identical in both groups. This is not surprising considering the expected high morbidity and mortality in patients presenting to the hospital with ICB. Our patients were seen to develop the complications of hypernatremia, hyponatremia, and diabetes insipidus at a greater frequency than were the patients where mannitol was not used. We also have discovered that mannitol osmotherapy was improperly used in the majority of cases; serum osmolarity, serum sodium, and urinary osmolarity were inadequately monitored. The goal of an increased serum osmolarity by 10 mOsm was not achieved in five out of ten mannitol subjects while three patients had the complication of diabetes insipidus. We believe our study was reflective of the problems that exist with the treatment of ICB in a community hospital setting. Invasive monitoring of ICP does not exist and as a result medical therapy remains empiric at best. Medical residents in their frustration often employ a battery of pharmacopoeia without realizing the possible complications of their therapy.

No reliable noninvasive method of monitoring neurological patients with suspected increased ICP exists, and clinical documentation of increased ICP is fraught with many inaccuracies.[2] Some of these problems have been addressed in our study. The next step would include a prospective study examining any potential benefits of mannitol osmotherapy in a double-blind randomized fashion. At the present time, it remains the author's opinion that osmotherapy with mannitol is imprecise in the community hospital setting without invasive monitoring of ICP and carries the risk of increased complications to the patients, without offering a greater chance of neurologic improvement. ■

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Clinical Consultations and Letters

MORRIS H. SAFFRON, MD

Ippolito Francesco Albertini, Francesco Torti, and Other Physicians. Translated and Annotated by Saul Jarcho (The Countway Library, Boston, MA, 1989).

By the mid-14th century, the ancient University of Bologna already had attracted a group of physicians, anatomists, and surgeons who made the rising medical school a magnet for students from the northern countries of Europe. Among the earliest and most celebrated of these teachers was Taddeo Alderotti (1225-1300), admired by Dante who named him the "Hippocratist" because of his attachment to the recently recovered writings of the Greek master. It was Alderotti who adopted and popularized a hitherto little known form of medical literature, the "Consilia." In most instances, these were the responses of a consultant to a request for information about a case that had puzzled the patient's own physician. Apparently the usefulness of this literary form persisted until the early 18th century and the present volume is a splendid example of its endurance. Translated and commented on by the eminent New York medical historian, Saul Jarcho, this book is the consultation reports of several physicians of the 18th century Bolognese school. Of these, the most fully represented in this collection is Ippolito Francesco Albertini (1660-1738). A student of Marcello Malphigi (1625-1684), discoverer of the capillaries and founder of the science of histology, Albertini was praised on several occasions in his pivotal "De Sedibus" by the pioneer of clinical pathology Giovanni Battista Morgagni (1662-1771). We know that Albertini continued his medical research until late in life, for in 1731 he published a paper on dyspnea as related to structural disease of the heart, considered sufficiently important to warrant reprinting 100 years later by the famous scholar Moritz Romberg.

In this time-honored format, the 171 case reports provide us with an intimate source of information on prevalent diseases, therapeutic agents, and the continued use of such ancient methods as bloodletting. Of the various forms of fever, the tertian, quartan, and intermittent, now called malarial, seem to have been well understood, and the use of cinchona or Peruvian bark has become standard in such cases. On the other hand, failure of cinchona in phthisis or pulmonary tuberculosis and in other febrile conditions already is recognized. In the gamut of common diseases covered, we may mention arthritis, epilepsy, anasarca, the two common venereal disorders, neurologic diseases, diabetes, and intestinal complaints. Ophthalmia frequently is discussed, but scabies is not related to the acarus first described by Bonomi in 1687.

It is interesting to note that for these writers the fame of Galen as the supreme authority of the Middle Ages has by now diminished in favor of Hippocrates and Celsus. Our authors also are aware of developments in contemporary medicine, and there are references to English authorities, including Robert Morton and Robert Willis, the student of the brain and nervous system, and Thomas Sydenham, the so-called "English Hippocrates" whose influential writings spread throughout Europe and as far as the American colonies.

This work is a splendid contribution to our knowledge of medicine as it was practiced in 18th century Italy. It offers us an insight into the mind of the consultant and we can feel a sense of closeness to him as he correlates the case under consideration with others of a similar nature. With Dr. Jarcho's illuminating commentary to guide us, we can recognize the basis for the many erroneous theories of causation. Considering the physician's limited diagnostic resources, we still must admire his acumen and powers of observation. What is certain is that the reading of this book should make us humble as we ponder on the progress of scientific medicine during the past two centuries. ■

Dr. Saffron is the MSNJ Archivist.

NOTEBOOK

TRUSTEES' MINUTES

A meeting of the MSNJ Board of Trustees was held on November 18, 1990, at the executive offices in Lawrenceville. Detailed minutes are on file with the secretary of your county society; a summary of significant actions follows:

Report of the President . . .
(1) Governor's Commission Report . . . Received the position statement made on behalf of MSNJ by Doctor Costabile before the Senate Committee on Institutions, Health and Welfare in response to the Governor's Commission on Health Care Costs.
(2) AMA Delegate . . . Noted the resignation of Frederick W. Durham as an AMA delegate; candidates for the position will be considered at the Nominating Committee meeting on January 30, 1991.
(3) Membership Recruitment and Retention . . . Approved formation of a committee to engage in membership recruitment and retention, to be chaired by Dr. Moss.
(4) Pennsylvania Blue Shield (PBS) Medicare Physicians Advisory Council . . . Observed that it will be necessary for PBS to promote a good relationship with the physician providers and senior citizens in the states they represent as part of their plan to be one of the potential mega-carriers in the country; Dr. Samson is to establish the protocol for the next meeting of the Council.

Report of Executive Director . . .
(1) MSNJ Membership . . . Provided a membership report for the information of the Board.
(2) MSNJ Financial Statements . . . Reviewed and approved the financial statements for the periods ending September 30, 1990, and October 31, 1990.
(3) No-Fault Litigation . . . Noted that a decision on the $100 assessment is expected soon and that arguments on the no-fault fee schedule and the ban on balance billing will be consolidated and completed before the end of the year.
(4) Senate Hearing on Governor's Commission Report . . . Noted the following: responses from letters sent to members of the state Legislature along with copies of "Health Access New Jersey" were reviewed; Assemblyman James McGreevy's bill on Medicare assignment is in the Assembly; legislative actions on a recommendation from the Governor's Report on rebundling physician reimbursement for hospital services into hospital bills will be concentrated in the Assembly; and a ban on physician self-referral and physician certificate of need will be introduced in the Senate.
(5) Regulatory Matters . . . Noted the following: the automobile no-fault fee schedule has not yet been adopted; the State Board of Medical Examiners is developing a new regulation related to physical therapy modalities; and a meeting is being scheduled with the Commissioner of Health to discuss the pending CLIA implementation and other significant regulatory items.
(6) Accounts Receivable Poll . . . Voted to have MSNJ staff investigate the possibility of conducting a selective poll of the membership to determine the members who have computer accounts receivable records that could be furnished to other members not having access to such records.
(7) MSNJ "800" Number . . . Advised the staff to proceed with the investigation of an "800" number to service physicians in the 201 area code.
(8) National Practitioner Data Bank . . . Requested Mr. Maressa to seek a formal advisory opinion as to whether physicians that have not complied with CME requirements need to be reported to the Data Bank.
(9) Physicians' Health Program . . . Voted to reappoint Dr. Palma Formica and Dr. Gerald Rozan as MSNJ's representatives on the Board of Directors of the Physicians' Health Program.

Specialty Reports . . . Received reports from the University of Medicine and Dentistry of New Jersey and from the New Jersey Hospital Association.

Senior Citizens Task Force . . . Referred the matter of pharmacies posting prices of the most popular medications for the purpose of comparative shopping to the Committee on Senior Citizens for consideration and discussion with the state pharmacy association.

Unfinished Business . . .
(1) Replacement of Medicare Carrier . . . Reviewed the response from Mr. Louis Hays, associate administrator for operations at HCFA, reassuring MSNJ that Pennsylvania Blue Shield's

(PBS) overall performance is sound and a review of all Medicare carriers is near completion; he promised to see that any remaining deficiencies identified at PBS are addressed and corrected.

(2) Proposed Comprehensive AIDS/HIV Legislation . . . Received for its information a letter from Mr. Louis Scibetta thanking MSNJ for support and comments on the proposed legislation and forwarded to the Task Force on AIDS Dr. Costabile's letter from Michel-Ange Ferdinand, MD, president of the Haitian American Services Center deploring the exclusionary blood donor policy of the United States Food and Drug Administration regarding Haitian and African immigrants.

New Business . . .

(1) Open Enrollment Group Insurance Plan for New Jersey Elderly . . . Voted to appoint an ad hoc committee, to be chaired by Dr. Copeland, to investigate the discussion concerning open enrollment group insurance plan for New Jersey elderly, covering physician fees only.

(2) Medicare Notification of Payment . . . Will submit the following resolution to the 1991 House of Delegates for consideration:

Resolved, that MSNJ request that, at the very least, the Medicare carrier acknowledge receipt and disposition of nonassigned claims; and be it further

Resolved that this resolution be forwarded to the AMA with the request that the Health Care Financing Administration give serious attention to this problem. □

UMDNJ NOTES

UMDNJ Creates Geriatric Education Center—The University of Medicine and Dentistry of New Jersey (UMDNJ) has received a federal grant to establish the state's first Geriatric Education Center to train health care professionals to improve the health care of New Jersey's one million elderly. Through a statewide network comprising UMDNJ and other collaborating institutions, the Center will provide extensive geriatric educational programs to academicians and practitioners in six disciplines—medicine, dentistry, nursing, physical therapy, nutrition, and respiratory therapy. The program will create a cadre of professionals who will be prepared to provide advanced health care to the elderly.

Community Collaboration Fights Drug Abuse. The U.S. Department of Health and Human Services (HHS) has awarded $1.5 million to UMDNJ-Robert Wood Johnson Medical School to promote drug abuse prevention. The grant will fund UMDNJ's Community Partnership for the Prevention of Drug and Alcohol Problems Among Latino Adolescents in Perth Amboy. The grant will fund phase two of an effort begun last year by Dr. Marilyn Aguirre-Molina, assistant professor of environmental and community medicine, and Perth Amboy residents to break the chain of events that often lead Latino adolescents to abuse alcohol and addicting drugs. Under the new grant, the Partnership will follow 20 Perth Amboy Latino families in depth for the next five years to identify the influences that lead some children to abuse drugs and those influences that strengthen other children to abstain from drugs.

Researchers Link Alcoholism and AIDS. A preliminary study of inner-city alcoholics conducted at UMDNJ-New Jersey Medical School has revealed that about 5 percent of them have been infected with the AIDS virus. While the rate of infection still is considerably lower than that found in intravenous drug users, the researchers say that the 1-in-20 rate could indicate that the problem is just emerging in this population. All of the alcoholics interviewed admitted that they always drink before or during sexual activity, and that puts them more at risk for contracting the AIDS virus because alcohol impairs ability. In addition, alcohol abuse may damage the immune system.

Dr. Steven Schleifer and Dr. Steven E. Keller, associate professors of psychiatry at the Newark-based medical school, have received a five-year $1.6 million grant from the National Institute of Alcohol Abuse and Alcoholism to continue their research. Over the next five years, the project team will track 300 to 400 people, half of whom are being treated for alcohol and/or drug abuse at the medical school's Alcohol Treatment Center. The others will be volunteers who do not abuse alcohol.

Dr. Inouye Gains MERIT Award. Dr. Masayori Inouye, professor and chairman of the Department of Biochemistry at UMDNJ-Robert Wood Johnson Medical School, Piscataway, has received a prestigious national award for his research into the processes that regulate cell growth. The award, a Method To Extend Research in Time (MERIT) Award, is presented by the National Institutes of Health (NIH).

Dr. Inouye's cell research has focused on what hapens to cell growth when the production of specific proteins necessary for growth is inhibited; how a cell relays information from its outer environment into its interior to activate the production of the proteins necessary for cell growth; and what happens to cell growth when certain genes have been altered, producing mutated forms of the proteins involved in the growth function. His research attempts to explain such things as how and why cancerous tumors occur and how cells adapt to new environments. He also is working on a non-drug technique to fight viral infection and replication in humans. □

Stanley S. Bergen, Jr, MD

AMNJ REPORT

The Board of Trustees of the Academy of Medicine of New Jersey has named the 1991 recipients of the awards to be presented at our Annual Awards Dinner on Wednesday, May 29, 1991, to be held at the Chanticler in Short Hills.

Robert V.P. Hutter, MD, of Livingston, will receive the Edward J. Ill Award "presented annually to that physician of New Jersey who merits recognition by the Academy for distinguished service as a leader in the medical profession." Dr. Hutter is chairman of the Department of Pathology at Saint Barnabas Medical Center, Livingston. He has served the medical community of New Jersey as a premiere consultant in pathology and as an active participant in local, state, national, and international affairs. He is acclaimed as one of the foremost experts in the pathology of breast cancer, thyroid cancer, and sarcomas. His extensive contributions to the American Cancer Society led to his election as its national president in 1982. He also has held high office in numerous state and national professional associations.

The Academy's Citizen's Award is "presented annually to that citizen or group of citizens of New Jersey who merit recognition by the Academy for distinguished service in the interest of the health and welfare of the community at large." The 1991 Citizen's Award has been granted to Vincent A. Maressa, Esquire, of Titusville.

Mr. Maressa is the executive director and legal counsel of the Medical Society of New Jersey. During the malpractice crisis of the mid-1970s he was instrumental in the formation of the New Jersey State Medical Underwriters. His leadership in that organization continues today and is reflected in his recent election as chairman of their Board of Directors. In addition, he has volunteered his time on numerous occasions to provide legal assistance to many of our state's medical specialty societies as well as the Academy of Medicine of New Jersey.

The Academy continues to expand its CME programs through funding from the New Jersey State Department of Health. The Division of AIDS Prevention and Control funds all of the AIDS-related projects. There are three roving symposia series, all of which are updated annually: "Diagnosis and Treatment of AIDS"; "Identification and Management of Asymptomatic HIV-Infection"; and "AIDS Training and Resource Program for Hospital Health Educators."

The AMNJ/MSNJ statewide physician assessment of physician's counseling and testing knowledge, attitudes, and practice management of HIV-infected patients has just completed the third year of a longitudinal study. The results of this survey will be published in *The Journal of Continuing Education in the Health Professions.*

AIDSLINE enters its third year of service to the medical community acting as a central resource linking AIDS-related education programs and speakers with physicians, nurses, hospitals, community service organizations, and the New Jersey State Department of Health, Division of AIDS Prevention and Control. A monthly newsletter is mailed to 4,000 health care providers who work with the HIV+ population. AIDSLINE responds to hundreds of physicians' requests for information, assistance, and referrals.

The Diabetes Control Program of the New Jersey State Department of Health funded another three-year award for four Roving Symposia Series: "Diabetes Related Nephropathy"; "Retinopathy, Diabetes, and Pregnancy"; and "Prevention of Diabetes Related-Lower Extremity Amputations." In addition, the Academy will publish a training manual on the outpatient management of the diabetic foot. Arthur Krosnick, MD, is the primary author of the protocol.

A new Roving Symposia series, "Recognizing and Treating Medical Disorders in People with Developmental Disabilities," cosponsored by the New Jersey Division of Developmental Disabilities and Mainstreaming Medical Care, a project of the Association for Retarded Citizens (ARC)-New Jersey was initiated in September and presently is scheduled in hospitals throughout the state.

Plans are underway for the AMNJ/MSNJ joint programs at the MSNJ Annual Meeting. □
Stanley Bresticker, MD, President

MSNJ AUXILIARY

"AIDS: A Guide To Survival For Teens" was the subject of the Auxiliary's health education day held at MSNJ headquarters. Attended by 350 teachers, counselors, nurses, and high school students, the symposium provided education in preventing the spread of the acquired immunodeficiency syndrome (AIDS) among adolescents and young adults. The panel of experts discussed the nature of the human immune virus (HIV) that causes AIDS as well as specific actions teens can take to protect themselves from the disease. The speakers, noting that the virus is transmitted almost exclusively by behavior that individuals can modify, e.g. having sexual contact with infected persons or by sharing intravenous drug needles/syringes with infected persons, emphasized the importance of continuing educational programs to influence relevant types of behavior in preventing the spread of HIV. Prevention, they stressed, is the only effective AIDS control strategy.

James M. Oleske, MD, professor of pediatrics at the University of Medicine and Dentistry of New

Jersey and one of the first physicians in the country to claim that AIDS could be passed from a mother to her fetus, spoke on juvenile AIDS. Dr. Oleske cautioned his audience that if we do not mobilize resources and if young people do not help to come up with solutions, change their behavior, influence their peers, and keep themselves from getting infected with the virus, by the year 2000, there could be 10 million Americans infected with the virus and possibly 250 million worldwide.

Mary Boland, RN, MSN, director of Children's Hospital AIDS Program of New Jersey (CHAPS), discussed "Generations in Jeopardy," a report from the New Jersey Pediatric AIDS Advisory Committee. She noted New Jersey has one of the worst rates of HIV infection in the country. Twenty-five percent of those suffering with AIDS are women and children, and 1 in 200 children are born to women with the HIV infection. New Jersey ranks third in the incidence of HIV infection in children and fifth in the nation in reported cases of AIDS. It is the leading cause of death in New Jersey for women between the ages of 15 and 44. Also, there has been an increase in teenagers treated for AIDS.

Diane Cole, AIDS education coordinator, New Jersey State Department of Education, Division of General Academic Education with the Bureau of Student Behavior and Development, reported on "AIDS and HIV Prevention Education." Cole described the many misconceptions teenagers have about AIDS and made a strong case for the need to develop comprehensive AIDS education programs in our schools. In 1990, the New Jersey State Board of Education adopted a revised health, safety, and physical education code in which school districts are instructed to develop a comprehensive school health education program, kindergarten through 12, including HIV prevention education. The New Jersey State Department of Education is receiving federal funding for the AIDS prevention education program. Monies are used to provide information to the schools, to administrators, to instructional staffs, and to the 1.1 million students at all grade levels. The Centers for Disease Control conducted studies that show a comprehensive school education program can be effective in changing students' knowledge, attitudes, and behaviors.

Finally, a personal story was conveyed by Carol DiPaolo. Her 11-year-old son Joey is HIV positive as a result of a contaminated blood transfusion. Mrs. DiPaolo pleaded with the audience to never forget that AIDS victims have feelings. She urged students and educators to develop a compassionate attitude and healthy respect for those infected with the virus. "Reach out and touch. Gain a better insight and knowledge into AIDS, into the people, and understand that it could happen to any of us." □ Marion H. Geib

PLACEMENT FILE

The following physicians have written to the executive offices of MSNJ seeking information on possible opportunities for practice in New Jersey. The information has been supplied by the physicians. If you are interested in any further information concerning these physicians, we suggest you make inquiries directly to them.

ANESTHESIOLOGY

Michael Silverberg, MD, 2020 Walnut St., Apt. 29K, Philadelphia, PA 19103. Yale 1983. Board eligible. Group or hospital. Available July 1991.

CARDIOLOGY

George D. Birmingham, MD, 3531 Salerno Ct., Apt. 5, Middleton, WI 53562. Mount Sinai 1984. Board eligible. Board certified (IM). Group or partnership. Available July 1991.

INTERNAL MEDICINE

Marc Kesselhaut, MD, 1 Rustic Ridge, C16, Little Falls, NJ 07424. St. George's University 1986. Board eligible. Solo or partnership in Mercer, Somerset, Burlington, Hunterdon, or Middlesex counties. Available.

PATHOLOGY

Charles F. Romberger, MD, 4501 Park Glen Rd., #241, St. Louis Park, MN 55416-4874. Temple 1986. Board eligible. Partnership or group. Available.

PEDIATRICS

Donna Churlin, MD, 55 Montgomery St., Bloomfield, NJ 07003. UMDNJ 1987. Board eligible. Partnership or group in central New Jersey (Essex, Union, or Morris counties). Available July 1991.

PHYSICAL MEDICINE AND REHABILITATION

Robert B. Thorne, MD, 112 Woodside Ave., Trenton, NJ 08618. Rutgers 1980. Board certified. Part time or full time. Available.

SURGERY

Donna Vecchione, MD, 27700 Bishop Park Dr., 4025, Willoughby Hills, OH 44092. SUNY-Stony Brook 1985. Board eligible. Partnership, solo, multispecialty group. Available.

UROLOGY

Jeffrey L. Gevirtz, MD, 400 Narragansett Pkwy., Apt. SC7, Warwick, RI 02888. UMDNJ-Robert Wood Johnson Medical School 1986. Board eligible. Group or partnership. Available July 1991.

S. Misra, MD, 8161 Gatewood Dr., Clay, NY 10341. SCB-Orissa (India) 1977. Board eligible. Group or partnership. Available July 1991.

MSNJ Annual Meeting
April 28-May 1, 1991

1991 MSNJ ANNUAL MEETING

The Board of Trustees of the Medical Society of New Jersey approved the Committee on Annual Meeting's recommendation that the 1991 Annual Meeting be held at the Trump Taj Mahal Casino Resort in Atlantic City, on Sunday, April 28, through Wednesday, May 1, 1991. The Merv Griffin's Resorts Casino Hotel will participate with the headquarters hotel (Trump Taj Mahal) for the 1991 Annual Meeting. The daily schedule follows:

Saturday, April 27, 1991

3:30 p.m. Board of Trustees' Meeting

Sunday, April 28, 1991

8:00 a.m. Registration Opens
8:00 a.m. Message Center Opens
10:00 a.m. Educational Programs
11:30 a.m. Exhibits Open
1:30 p.m. House of Delegates
3:30 p.m. Reference Committee Meetings

Monday, April 29, 1991

8:00 a.m. Registration Opens
8:00 a.m. Message Center Opens
8:30 a.m. Exhibits Open
9:00 a.m. House of Delegates (Election)
12:00 noon Golden Merit Award Ceremony and Reception
2:30 p.m. Reference Committee Meetings
5:00 p.m. JEMPAC Political Forum
5:45 p.m. JEMPAC Wine and Cheese Reception
6:30 p.m. Union County Medical Society Reception

Tuesday, April 30, 1991

8:00 a.m. Registration Opens
8:00 a.m. Message Center Opens
8:30 a.m. Exhibits Open
9:00 a.m. House of Delegates
1:30 p.m. House of Delegates
7:00 p.m. Inaugural Reception and Dinner
honoring Doctor and Mrs. Joseph A. Riggs

Wednesday, May 1, 1991

8:00 a.m. Registration Opens
8:00 a.m. Message Center Opens
8:30 a.m. Educational Program
1:00 p.m. Board of Trustees' Meeting

HOUSING APPLICATION

225th ANNUAL MEETING
THE MEDICAL SOCIETY OF NEW JERSEY
APRIL 28-MAY 1, 1991

Select the hotel of your choice. Mail the entire form with one night's deposit to that hotel.

TRUMP TAJ MAHAL CASINO/RESORT (Headquarters Hotel)

1000 BOARDWALK AT VIRGINIA AVENUE, ATLANTIC CITY, NJ 08401
RESERVATION DEPARTMENT 1-800-825-8786

(Please Print)

Name _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Business Phone _____

Sharing With _____

Date of Arrival _____ Time _____

Date of Departure _____ Time _____

A one-night deposit (equivalent to room rate) is required with all reservation requests. Please send check or money order payable to the **TRUMP TAJ MAHAL CASINO & RESORT** or complete the following:

Card # _____ Type _____ Exp. Date _____

SCHEDULE OF RATES SUBJECT TO 13% TAX

☐ SINGLE **$115** ☐ DOUBLE **$115** **(Reservations must be received prior to March 29, 1991)**
Extra Person **$25**

☐ One-Bedroom Suite **$275 per day**

☐ One-Bedroom Hospitality Suite **$275 per day**

Check-out time is 12 Noon. Rooms may not be available for check-in until after 3 p.m. Check-in time on Sundays is 5 p.m. FORTY-EIGHT (48) HOURS NOTICE OF CANCELLATION is required for a full refund.

PARKING: FREE PARKING TO REGISTERED GUESTS. One car per room.

☐ Check if Official Delegate _____ County _____

★★★

The Subcommittee On Alcohol and Drug Abuse
of the
Committee On Physicians' Health
of the Medical Society of New Jersey
and the Academy of Medicine of New Jersey
in conjunction with
New Jersey Physicians in the American Society of Addiction Medicine

PRESENTS

A ONE-DAY SEMINAR ON

ISSUES IN CHEMICAL DEPENDENCY

Wednesday, February 6, 1991
Somerset Hilton Hotel
Somerset, New Jersey
8:00 A.M.-4:00 P.M.

Application has been made for Category I CME Credits

Registration Fee: $20.00

For more information, contact the Physicians' Health Program at (609) 896-1766.

REGISTRATION FORM

Name _____

Address _____

Telephone (h) _____ (o) _____

Please complete and mail with your $20 registration fee to:

Physicians' Health Program
Medical Society of New Jersey
2 Princess Road, Lawrenceville, New Jersey 08648

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June 10-14th, 1991

Update Your Medicine Seventeenth Annual CME Course with Hands-on Workshop. New York City sponsored by the Dept. of Medicine Cornell University Medical College and the Association of Practicing Physicians of the New York Hospital. Category I credit. Information: Lila A. Wallis, MD, Director and Debora A. Laan, Coordinator/445 East 69th Street, Olin 328, New York, NY 10021. Telephone: 212-746-4752

TWELFTH ANNUAL

COMPREHENSIVE COURSE IN OCCUPATIONAL MEDICINE

UNIVERSITY OF MEDICINE AND DENTISTRY OF NEW JERSEY

DEPT. OF ENVIRONMENTAL AND COMMUNITY MEDICINE
ROBERT WOOD JOHNSON MEDICAL SCHOOL
PISCATAWAY, NEW JERSEY

DATE:
April 2-19, 1991/15 weekdays/8:30 a.m.-4:30 p.m.,6 evening classes/6:30-8:30 p.m.

PURPOSE:
To provide a comprehensive review of key issues and concepts in Occupational Medicine given by eminent specialists from university, government and industry. To aid in obtaining board eligibility and certification.

ACCREDITATION:
The University of Medicine and Dentistry of New Jersey-Center for Continuing Education certifies that this continuing medical education activity meets the criteria for 90 hours of credit in Category 1 for the Physician's Recognition Award of the American Medical Association, provided the program is completed as designed.

SUBJECTS:
Industrial Hygiene, Occupational Disease, Toxicology, Practice of Occupational Medicine, Epidemiology and Biostatistics, Ergonomics, Public Health Administration.

INQUIRIES:
Maryellen Bifano
UMDNJ-Center for Continuing Education
675 Hoes Lane, Piscataway, NJ 08854-5635 (201) 463-4707

Sleep & Breathing *A Medical Overview for the 1990s*

Wednesday, April 3, 1991
Morristown Memorial Hospital Grand Rounds
Full Day Program With Luncheon

"Treatment of Obstructive Sleep Apnea with CPAP & BiPAP"
Mark H. Sanders, M.D., FCCP
Director, Pulmonary Sleep Evaluation Laboratory
Presbyterian-University Hospital, Pittsburgh, PA

"Clinical Aspects of Sleep Apnea"
David M. Rapoport, M.D., FCCP
Medical Director, Bellevue Sleep Laboratory, New York, NY

"Sleep and Other Respiratory Disorders"
Robert A. Capone, M.D., FCCP
Medical Director, Sleep Disorder Center of Greater New Jersey
Morristown Memorial Hospital, Morristown, NJ

• Case Presentations • CME Credits
For registration call

1-800-447-3337

SLEEP DISORDER CENTER OF GREATER NJ

a service of
MORRISTOWN MEMORIAL HOSPITAL
A major teaching affiliate of the Columbia University College of Physicians and Surgeons

JEFFERSON MEDICAL COLLEGE
OF
THOMAS JEFFERSON UNIVERSITY
Department of Neurology

presents

Reflex Sympathetic Dystrophy: Current Strategies in Diagnosis and Treatment

May 3 and 4, 1991
at
Jefferson Medical College
McClellan Hall

Program Directors:
Robert J. Schwartzman, M.D.
Robert L. Knobler, M.D., Ph.D.
Audrey F. Thomas, B.A., R.N.

FOR ADDITIONAL INFORMATION, CALL:
Continuing Medical Education, Jefferson Medical College
(215) 955-6992

CONTINUING EDUCATION

ANESTHESIOLOGY

February

1-3 **Advances in Pain Management**
Yacht and Beach Club, Walt Disney World, Lake Buena Vista, Florida
(UMDNJ)

March

16-17 **32nd Annual Postgraduate Anesthesia Seminar**
All day—The Hyatt, Cherry Hill
(NJ State Society of Anesthesiologists)

CARDIOLOGY

March

6 **Indications for Noninvasive Studies**
10:30-11:30 A.M.—Christ Hospital, Jersey City
(AMNJ)

8 **Newer Cardiac Drugs**
1-2 P.M.—North Princeton Developmental Center, Princeton
(AMNJ)

DERMATOLOGY

February

12 **Liposuction**
7-9 P.M.—Schering Corporation, Kenilworth
(Dermatological Society of New Jersey)

13 **Common Dermatoses**
1:30-2:30 P.M.—Runnells Specialized Hospital, Berkeley Heights
(AMNJ)

20 **Case Presentations**
6 P.M.—Rutgers Community Health Plan, U.S. Route 1, New Brunswick
(UMDNJ, Division of Dermatology)

March

12 **Dermatology Meeting**
7-9 P.M.—Schering Corporation, Kenilworth
(Dermatological Society of New Jersey)

14 **Update on Superficial Fungal Infections**
10-11 A.M.—Hunterdon Developmental Center, Clinton
(AMNJ)

20 **Case Presentations**
6 P.M.—Rutgers Community Health Plan, U.S. Route 1, New Brunswick
(UMDNJ, Division of Dermatology)

INFECTIOUS DISEASE

March

4 **Diagnosis and Treatment of AIDS**
1-2 P.M.—New Lisbon Developmental Center, New Lisbon
(AMNJ)

5 **Diagnosis and Treatment of AIDS**
9-10 A.M.—Union Hospital, Union
(AMNJ and NJDOH)

MEDICINE

February

1 **Living Wills**
12 Noon-1 P.M.—South Jersey Hospital System, Bridgeton
(AMNJ)

2 **Podiatry Meeting**
8 A.M.-4 P.M.—New Jersey Medical School, Newark
(UMDNJ)

2-5 **8th Annual Pain Management**
8 A.M.-1 P.M.—Walt Disney World, Lake Buena Vista, Florida
(UMDNJ)

5 **Fifth Annual Internal Medicine**
12 **Update and Board Review**
19 5:30-7:30 P.M.—Cooper Hospital/
26 University Medical Center, Camden
(Cooper Hospital/University Medical Center)

5 **Issues in Public Health**
19 12:15-1:30 P.M.—Health and Agriculture Building, Auditorium, Trenton
(NJDOH and AMNJ)

6 **Living Wills**
10:30-11:30 A.M.—Christ Hospital, Jersey City
(AMNJ)

6 **Internal Medicine Review**
13 **Course**
20 4-7 P.M.—University Hospital,
27 New Brunswick
(AMNJ and UMDNJ)

6 **Diabetes in Pregnancy**
11:30 A.M.-12:30 P.M.—Rahway Hospital, Rahway
(AMNJ)

6 **Nonoperative Management of Chronic Back Pain**
10:30-11:30 A.M.—St. Mary's Hospital, Passaic
(AMNJ)

6 **Treating Medical Disorders in People with Developmental Disabilities**
9-10 A.M.—Warren Hospital, Phillipsburg
(AMNJ)

6 **Endocrine Rounds**
13 3:30-5 P.M.—University Hospital,
20 Newark
27 *(AMNJ)*

8 **Diabetic Nephropathy**
1-2 P.M.—North Princeton Developmental Center, Princeton
(AMNJ)

11 **DRG/Cost Containment**
7-8 P.M.—Wallkill Valley General Hospital, Sussex
(AMNJ)

12 **Internal Medicine Update and**
19 **Board Review**
26 5:30-7:30 P.M.—Cooper Hospital/ University Medical Center, Camden
(Cooper Hospital/University Medical Center)

13 **Learning Disabilities**
10:30-11:30 A.M.—St. Mary's Hospital, Passaic
(AMNJ)

13 **Chronic Epstein-Barr Virus**
1:30-2:30 P.M.—Essex County Hospital Center, Cedar Grove
(AMNJ)

15 **Neuro-Ophthalmology**
12 Noon-1 P.M.—South Jersey Hospital System, Bridgeton
(AMNJ)

20 **Managing Stress Effectively**

The Comprehensive Headache Center
at The Germantown Hospital and Medical Center
in cooperation with Temple University School of Medicine, Department of Neurology
Presents

The Sixth Headache Symposium

Update in the Diagnosis and Treatment of Headache, Facial Pain and Neuralgia

Presented by a nationally known panel of headache experts.

■

Saturday, March 16, 1991
8:30 A.M. - 3:15 P.M.
at The Germantown Hospital and Medical Center
One Penn Boulevard, Philadelphia, PA
(adjacent to LaSalle University at the intersection of Wister, Chew and Olney Avenues)

Featured Speakers and Topics:

Moderator: Elliott A. Schulman, M.D.*
Attending Neurologist,
The Germantown Hospital and Medical Center;
Associate Professor of Neurology,
Temple University Hospital

Pathogenesis and Current Treatment of Migraine
Stephen D. Silberstein, M.D.*
Chief, Neurology Section,
The Germantown Hospital and Medical Center;
Associate Professor of Neurology,
Temple University Hospital

The Emergency Treatment of Headache
John G. Edmeads, M.D.
Professor of Medicine (Neurology),
University of Toronto

Management of the Cranial Neuralgias and Atypical Facial Pain
Donald J. Dalessio, M.D.
Senior Consultant, Division of Neurology, Scripps Clinic and Research Foundation, LaJolla, California

Neuro-Ophthalmologic Complications of Migraine Diagnosis and Management of Idiopathic Intracranial Hypertension (Pseudotumor Cerebri)
James J. Corbett, M.D.
Professor and Chairman, Department of Neurology,
University of Mississippi Medical Center

COMPREHENSIVE HEADACHE CENTER
at The Germantown Hospital and Medical Center

Additional participants will include:

Gregory J. Tramuta, M.D.*, Chief, Psychiatry Section,
The Germantown Hospital and Medical Center;
Associate Clinical Professor of Psychiatry,
Temple University Hospital

Ronald S. Kaiser, Ph.D.*, Licensed Psychologist;
Affiliate, Psychiatry Section,
The Germantown Hospital and Medical Center;
Assistant Professor, Department of Psychiatry,
Temple University

Joseph P. Primavera, III, M.A.*, Licensed Psychologist; Affiliate, Psychiatry Section,
The Germantown Hospital and Medical Center

William B. Young, M.D., Attending Neurologist,
The Germantown Hospital and Medical Center

A round-table discussion will include controversial topics in headache management and difficult cases. Plan to bring your difficult cases for discussion.

*Co-Director, Comprehensive Headache Center

Funding for this Symposium provided by GLAXO, INC.

Credits:
5 Category I credits for AMA Physician's Recognition Award

Registration Fee:
$25.00 (includes coffee break, lunch and registration materials) Return by March 1, 1991.

Please make checks payable to:
The Germantown Hospital and Medical Center
Comprehensive Headache Center
One Penn Boulevard, Philadelphia, PA 19144

10:30-11:30 A.M.—St. Mary's Hospital, Passaic
(AMNJ)

21 **Prevention of Lower Extremity Amputations**
1:30-2:30 P.M.—Essex County Hospital Center, Cedar Grove
(AMNJ)

27 **Diabetic Nephropathy**
2:30-3:30 P.M.—Trenton Psychiatric Hospital, Trenton
(AMNJ and NJDOH)

28 **Visiting Professor Lecture**
1:30-5 P.M.—Saint Barnabas Medical Center, Livingston
(Saint Barnabas Medical Center)

March

1 **19th Annual Joint Conference**
8 A.M.-4 P.M.—Hyatt Regency, New Brunswick
(NJ Thoracic Society/NJ Chapter, American College of Chest Physicians)

5 **Internal Medicine Update and**
12 **Board Review**
19 5:30-7:30 P.M.—Cooper Hospital/
26 University Medical Center, Camden
(Cooper Hospital/University Medical Center)

6 **Diabetic Retinopathy**
9-10 A.M.—Warren Hospital, Phillipsburg
(AMNJ)

6 **Internal Medicine Review**
13 **Course**
20 4-7 P.M.—University Hospital,
27 New Brunswick
(AMNJ and UMDNJ)

6 **Endocrine Grand Rounds**
13 11:30 A.M.-1 P.M.—VA Medical
20 Center, East Orange
27 *(AMNJ)*

6 **Interhospital Endocrine Rounds**
13 3:30-5 P.M.—University Hospital,
20 Newark
27 *(AMNJ)*

6 **Dinner Meeting**
6-9 P.M.—Holiday Inn, Newark Airport
(Endocrinology Section, AMNJ)

13 **Treating Medical Disorders in People with Developmental Disabilities**
11:30 A.M.-12:30 P.M.—Rahway Hospital, Rahway
(AMNJ)

13 **CDS Prescribing Practices: Legal/Illegal**
10:30 A.M.-12 Noon—Christ Hospital, Jersey City
(AMNJ)

13 **Diabetic Nephropathy**
8-9 A.M.—Barnert Hospital, Paterson
(AMNJ)

18 **Functional Assessment of the Elderly**
11:30 A.M.-1 P.M.—East Orange General Hospital, East Orange
(AMNJ)

19 **Congenital Adrenal Hyperplasia**
8 A.M.—St. Joseph's Hospital and Medical Center, Paterson
(St. Joseph's Hospital and Medical Center)

19 **Adverse Reactions to Hemodialysis**
6:30-9:30 P.M.—Overlook Hospital, Summit
(Nephrology Society of New Jersey)

22- **East Coast Connective Tissue**
23 All day—Robert Wood Johnson Medical School, New Brunswick
(UMDNJ)

27 **Diabetic Retinopathy**
1:30-2:30 P.M.—Essex County Hospital Center, Cedar Grove
(AMNJ)

OBSTETRICS/GYNECOLOGY

February

6 **Diabetes in Pregnancy**
11:30 A.M.-12:30 P.M.—Rahway Hospital, Rahway
(AMNJ and NJDOH)

17- **Women's Health Care**
20 7:30 A.M.-1 P.M.—Walt Disney World, Lake Buena Vista, Florida
(UMDNJ)

25- **4th Annual Ob/Gyn Update**
3/1 All day—Stowe, Vermont
(UMDNJ)

28 **Nurse Midwifery Program**
9 A.M.-5 P.M.—Atlantic City
(UMDNJ)

March

1- **Annual Semmelweis Waters**
3 **Ob/Gyn**
8 A.M.-5 P.M.—Bally's Park Place Casino, Atlantic City
(UMDNJ)

ONCOLOGY

February

28 **Dinner Meeting**
6:30-9:30 P.M.—The Manor, West Orange
(Head and Neck Oncology Section, AMNJ)

March

6 **Tumor Board Conference**
6-9 P.M.—MSNJ Headquarters, Lawrenceville
(Oncology Society of New Jersey)

27 **Reception**
6:30-9:30 P.M.—The Manor, West Orange
(Radiation Oncology Section, AMNJ)

PEDIATRICS

March

1- **Advanced Life Support**
2 7:30 A.M.-4:30 P.M.—Shore Memorial Hospital, Somers Point
(AMNJ)

PSYCHIATRY

March

15 **Management of Patients with Chronic Aggression**
10-11 A.M.—Marlboro Psychiatric Hospital, Marlboro
(AMNJ)

RADIOLOGY

March

6 **Nuclear Medicine**
10:30-11:30 A.M.—St. Mary's Hospital, Passaic
(AMNJ)

14 **MRI of the Abdomen**
7:30-9:30 P.M.—Saint Barnabas Medical Center, Livingston
(Radiological Society of NJ/ AMNJ)

21 **Radiology Meeting**
Saint Barnabas Medical Center, Livingston
(Radiology Society of NJ/AMNJ)

SURGERY AND ITS SPECIALTIES

February

10- **12th Annual Vascular**
12 **Symposium**
8 A.M.-4:30 P.M.—Taj Mahal Hotel & Casino, Atlantic City
(UMDNJ)

March

13 **High-Risk Surgery**
10:30-11:30 A.M.—St. Mary's Hospital, Passaic
(AMNJ)

20 **13th Annual Meeting**
1:30-5 P.M.—Cooper Hospital/ University Medical Center, Camden
(Vascular Society of New Jersey)

UROLOGY

March

20 **Transurethral Resection**
10:30-11:30 A.M.—St. Mary's Hospital, Passaic
(AMNJ)

HU

Hahnemann University

Department of Medicine Grand Rounds 8:30 a.m.-9:30 a.m.

January 1991-March 1991

JANUARY 1991

January 2, 1991
No Grand Rounds

January 9, 1991
CARDIAC ARRHYTHMIAS:
DRUGS VERSUS DEVICES
Leonard S. Dreifus, MD
Professor of Medicine
Director, Heart Station
Likoff Cardiovascular Institute
Hahnemann University

January 16, 1991
SUBSTANCE ABUSE PREVENTION:
CAN WE WIN THE WAR?
Vincent J. Zarro, MD, PhD
Associate Professor of Medicine
Director, Division of Clinical Pharmacology
Hahnemann University

January 23, 1991
BIOLOGICAL WARFARE DEFENSE:
ROLE OF MOLECULAR BIOLOGY
Herbert A. Blough, MD
Capt. Medical Corps, USNR
Coordinator, Antiviral Molecular
Biology Program
Fort Detrich, Frederick, Maryland

January 30, 1991
CHRONIC FATIGUE SYNDROME
Isadora Brodsky, MD
Professor and Chairman
Department of Neoplastic Diseases
Hahnemann University
David R. Strayer, MD
Professor
Department of Neoplastic Diseases
Hahnemann University
David H. Gillespie, PhD
Professor
Director, Basic Research
Department of Neoplastic Diseases
Hahnemann University

FEBRUARY 1991

February 6, 1991
SYPHILIS, NEUROSYPHILIS, PENICILLIN
AND AIDS
Daniel M. Musher, MD
Professor of Medicine
Microbiology and Immunology
Baylor College of Medicine;
Chief, Infectious Diseases Section
Veterans Administration Medical Center

February 13, 1991
ERYTHROPOIETIN: RESPONSIBLE FOR RBC
PRODUCTION AND SURVIVAL
Allan B. Schwartz, MD
Professor of Medicine
Hahnemann University

February 20, 1991
GASTROINTESTINAL INFECTIONS
Sherwood L. Gorbech, MD
Chief, Infectious Disease Section
New England Medical Center
Boston, Massachusetts

February 27, 1991
TREATMENT OF BREAST CANCER
Marlin Abeloff, MD
Professor of Medicine
Chief of Medical Oncology
Johns Hopkins Oncology Center
Baltimore, Maryland

MARCH 1991

March 6, 1991
CLINICAL PATHOLOGICAL CONFERENCE CHIEF
MEDICAL RESIDENTS PRESENTATIONS
Marc Grobman, DO
An Pham, MD
Karen Tom, MD
Department of Medicine
Hahnemann University

March 13, 1991
A VIEW OF CORONARY REVASCULARIZATION
Robert L. Frye, MD
Professor and Chairman
Department of Medicine
Division of Cardiology, Mayo Clinic
Rochester, Minnesota

March 20, 1991
OPHTHALMOLOGY FOR THE INTERNIST,
SYSTEMATIC DISEASE AS SEEN
THROUGH THE EYE
Stephen Sinclair, MD
Professor of Ophthalmology
Vice Chairman, Department of Ophthalmology
Hahnemann University
Elliot Werner, MD
Associate Professor of Ophthalmology
Director, Glaucoma Service
Hahnemann University

March 27, 1991
NEW DERMATOLOGIC ANTIFUNGAL AGENTS
FOR CUTANEOUS INFECTIONS
Edgar B. Smith, MD
Professor and Chairman
Department of Dermatology
University of Texas, Medical Branch
Galveston, Texas

CUTANEOUS STAPHYLOCOCCUS AUREUS
INFECTIONS IN AIDS PATIENTS
James J. Leyden, MD
Professor of Dermatology
University of Pennsylvania
Philadelphia, PA

Hahnemann University Department of Medicine
Wednesday Medical Seminar Series
8:30 AM-3:30 PM

February 20, 1991
GASTROINTESTINAL INFECTIONS: Current Controversies

Course Director: Harris Clearfield, MD
Professor of Medicine
Director, Division of Gastroenterology
Hahnemann University

Guest Faculty: Sherwood L. Gorbach
Chief, Infectious Disease Section
New England Medical Center
Boston, Massachusetts

Topics:
- Traveler's Diarrhea
  - a. difficile Infection
  - b. pylori Disorders
- AIDS Diarrhea
- Diverticulitis
- Abscess & Other Surgical Complications of Diverticulitis
- Malabsorption Syndrome with Infectious Eliologies

March 27, 1991
CUTANEOUS INFECTIONS: Trends in Treatment

Course Director: Richard L. Spielvogel, MD
Professor of Medicine
Director, Division of Dermatology
Hahnemann University

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Edgar B. Smith, MD
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Professor of Medicine
and Chairman
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Allan B. Schwartz, MD
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3:30-4:00	The diagnosis and management of the hypertensive patient with complicated renal and cardiac disease	*Diane Jorkasky, M.D.*
4:00-5:00	Case Presentations	*Hope B. Helfeld, D.O.*
	Panel Discussion	
	William Corin, M.D.	*Mariell Jessup, M.D.*
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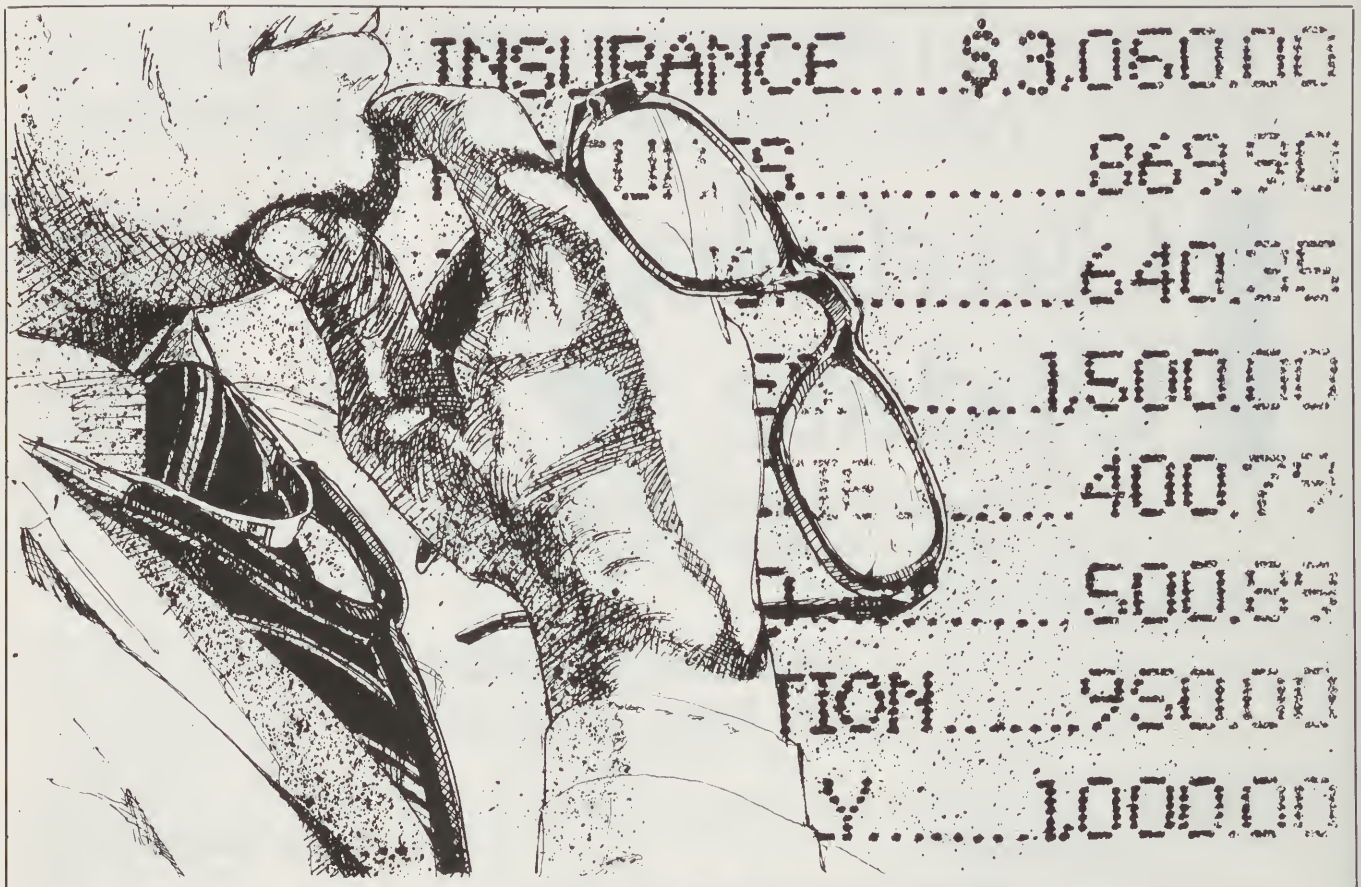
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IN MEMORIAM

Harold J. Bayer. A retired member of our Atlantic County component, Harold J. Bayer, MD, died on October 15, 1990. Born in Pittsburgh, Pennsylvania, in 1908, Dr. Bayer earned his medical degree from the University of Louisville School of Medicine, Kentucky, in 1931. Upon receiving his New Jersey medical license in 1946, Dr. Bayer served as chief of obstetrics and gynecology at Shore Memorial Hospital, Somers Point, and Atlantic City Medical Center. Dr. Bayer was a diplomate of the American College of Obstetricians; a fellow of the American College of Surgeons and of the International College of Surgeons; and a member of the New York and Philadelphia Obstetrics and Gynecology Societies. From 1943 to 1946, Dr. Bayer served as a lieutenant commander in the United States Navy. At the time of his death, Dr. Bayer was living in North Miami Beach.

William A. Berger. At the grand age of 87, William Adolph Berger, MD, died on September 23, 1990. Dr. Berger was a retired member of our Essex County component, living in Inverness, Florida, at the time of his death. A general surgeon, Dr. Berger earned his medical degree from the University of Maryland School of Medicine, Baltimore, in 1928. During his lengthy career, Dr. Berger was an attending surgeon at Saint Michael's Medical Center, Newark, and an associate attending surgeon at Columbia-Presbyterian Hospital, New York. Dr. Berger was a member of the Academy of Medicine of New York and of the American Medical Association; he was a fellow of the American College of Surgeons.

Bernard Bolten. Family practitioner Bernard Bolten, MD, of Livingston, died on August 20, 1990, at the age of 80. Dr. Bolten, born on November 16, 1909, in Newark, received his medical degree from St. Louis University School of Medicine, Missouri, in 1934 and his New Jersey medical license in 1936. Dr. Bolten interned at the former Newark City Hospital. Dr. Bolten maintained a practice in Newark and Irvington and was affiliated with Newark Beth Israel Medical Center, Newark; Lutheran Memorial Hospital, New York; St. James Hospital, Newark; and Clara Maass Medical Center, Belleville. Dr. Bolten retired from medical practice in 1989. During World War II, Dr. Bolten was a captain in the United States Army Medical Corps. Dr. Bolten was a member of the AMA and of our Essex County component.

Sol M. Donchi. Maplewood resident Sol Marvin Donchi, MD, born on April 16, 1898, died September 18, 1990, at the age of 92. Dr. Donchi came with his family to the United States from Latvia at the age of 2 and attended the University of Maryland School of Medicine, Baltimore, receiving his medical degree in 1927. One year later, he received his New Jersey medical license. Dr. Donchi served in the United States Infantry during World War I. During World War II, Dr. Donchi performed medical examinations to new military enlistees and was awarded the Selective Service Medal and a certificate of appreciation for this effort. A diplomate of the American Board of Otolaryngology, Dr. Donchi practiced in Kearny and Newark for many years and was affiliated with: Saint Michael's Medical Center, Newark; West Hudson Hospital, Kearny; Newark Beth Israel Medical Center; and the former Babies Hospital, Newark. Dr. Donchi was a member of our Essex County component and of the American Medical Association. Dr. Donchi retired from his private practice in 1982, working part-time at the Department of Veterans Affairs Medical Center, East Orange, until 1985.

Nicholas M. Gorog. Nicholas M. Gorog, MD, died in Florida on July 1, 1989, at the age of 91. An internist, Dr. Gorog was born in Budapest, Hungary, on December 19, 1898, and attended the University of Budapest, Hungary, earning his medical degree in 1924. Before coming to the United States, Dr. Gorog practiced in Budapest, writing several articles for the *Hungarian Medical Journal.* Dr. Gorog earned his New Jersey medical license in 1939. Dr. Gorog resided and practiced in New Brunswick prior to relocating to West Palm Beach, Florida. During his lengthy career, Dr. Gorog was a physician for the New Jersey Turnpike Authority. Dr. Gorog was affiliated with St. Peter's Medical Center, New Brunwick. Dr. Gorog served in the U.S. Army during World War II. Dr. Gorog was a member of our Middlesex County component and of the American Medical Association. Dr. Gorog also was a fellow of the Academy of General

Practice and the New Jersey Academy of General Practice.

Richard E. Lang. At the age of 75, ophthalmologist Richard Elmer Lang, MD, passed away on October 5, 1990. Dr. Lang died in Rome. Born in Milwaukee on March 26, 1915, Dr. Lang lived in Passaic, Upper Montclair, and Livingston. In 1940, Dr. Lang received his medical degree from Hahnemann Medical College, Philadelphia, and interned at St. Mary's Hospital, Passaic. Dr. Lang served a residency at Newark Eye & Ear Infirmary. He received his New Jersey medical license in 1941. Dr. Lang maintained a practice in Passaic. During his long medical career, Dr. Lang was affiliated with St. Mary's Hospital, Passaic, serving as president; Newark Eye & Ear Infirmary; and the General Hospital Center at Passaic. Dr. Lang was past-president of the Passaic Board of Education. Dr. Lang was a member of our Passaic County component, of the New Jersey Ophthalmological Society, and of the American Medical Association. Dr. Lang also was a fellow of the Academy of Medicine of New Jersey and of the International College of Surgeons.

William H. Lewis. Anesthesiologist William Henry Lewis, MD, died on August 5, 1990, at the age of 78. Born in Pittsburgh, Pennsylvania, Dr. Lewis was awarded his medical degree from the University of Pittsburgh School of Medicine, Pennsylvania, in 1937. He completed an internship at the University of Pittsburgh Hospitals, Pennsylvania, and at Sewickley Valley Hospital, Pennsylvania, in 1938, and received his license to practice medicine in Pennsylvania that year. From 1950 to 1962, he was affiliated with Morton Hospital, Taunton, Massachusetts, and in 1963 relocated to New Jersey. Upon receiving his license to practice medicine in 1963, Dr. Lewis became an associate attending for the Department of Anesthesia at Overlook Hospital, Summit. Dr. Lewis retired to Sun City, Arizona. He was a member of our Union County component, and a fellow of the American Society of Anesthesiologists. From 1943 to 1946, Dr. Lewis served in the U.S. Army, attaining the rank of captain.

Philip Opper. A former medical director of the Paterson Board of Education and a 53-year member of the Barnert Memorial Hospital Center medical staff, Philip Opper, MD, died on September 3, 1990. Dr. Opper retired from practice in 1988 and relocated to Key Biscayne, Florida. Born in 1913 in Paterson, Dr. Opper was awarded his medical degree from the University of Arkansas Medical School in 1937, and served his internship at Barnert Memorial Hospital, Paterson, the following year. In addition to his affiliation with the Paterson Board of Education from 1958 to 1988, he served as president of the medical staff at the Daughters of Miriam Center for the Aged, Clifton; chairman of the Department of Ophthalmology at Barnert Memorial Hospital in the 1960s; staff privileges at General Medical Center at Passaic, Paterson, and Saint Joseph Hospital and Medical Center, Paterson; past-president of the Paterson Medical Society; he was a retired member of our Passaic County component and of the AMA.

Paul Parker. Urologist Paul Parker, MD, of Hopkinton, New Hampshire, died August 8, 1990, at the age of 72. Born in Trenton on March 10, 1918, Dr. Parker received his medical degree from the University of Pennsylvania School of Medicine, in 1943 and his New Jersey medical license in 1946. Affiliated with Mercer Hospital, Trenton, and The Medical Center at Princeton, Dr. Parker practiced in Trenton. Dr. Parker was board certified in urology. Dr. Parker was a member of the American Medical Association and of our Mercer County component, and a fellow of the American College of Surgeons.

Sica L. Schmaier. Word has been received of the death of Sica Littman Schmaier, MD, in Philadelphia on March 9, 1990, at the age of 79. Dr. Schmaier received his medical degree from the University of Strasbourg, France, in 1939. Dr. Schmaier earned his New Jersey medical license in 1946. Born in Rumania in September, 1910, Dr. Schmaier maintained a family practice in Belmar and was affiliated with the former Fitkin Memorial Hospital, Neptune. Dr. Schmaier was a member of our Monmouth County component.

Francis S. Weinstein. Board certified otolaryngologist, Francis Saul Weinstein, MD, was born in Bridgeport, Connecticut, on March 12, 1910. Dr. Weinstein died on September 29, 1990, at the age of 80. After earning his medical degree from New York Medical College in 1935, Dr. Weinstein received his New Jersey medical license one year later. Dr. Weinstein interned at Flower Fifth Avenue Hospital, New York, and completed a residency at Bellevue Hospital, New York. Dr. Weinstein practiced in Newark and South Orange and was affiliated with Saint Barnabas Medical Center, Livingston; Newark Beth Israel Medical Center; and the former Harrison S. Martland Medical Center, Newark. Dr. Weinstein was chief of the ear, nose, and throat medical staff at Newark Eye and Ear Infirmary and at Irvington General Hospital. A professor at UMDNJ, Dr. Weinstein was a member of the American Medical Association and of our Essex County component. Dr. Weinstein was a fellow of the American Academy of Otolaryngology and Ophthalmology and of the American College of Surgeons.

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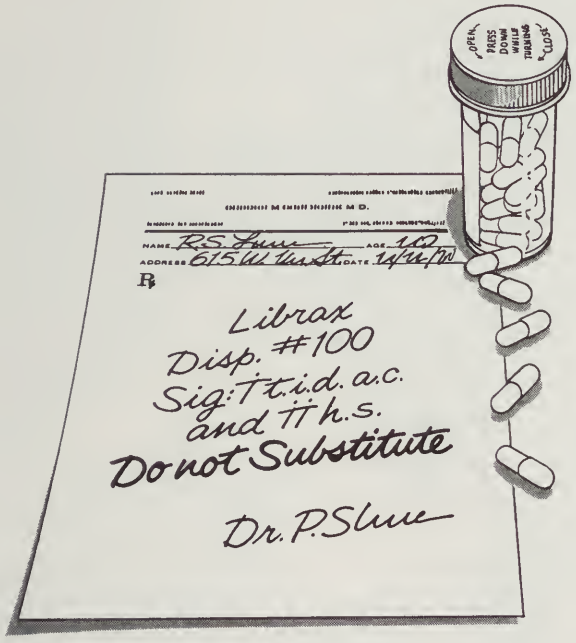
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As with all anticholinergics, inhibition of lactation may occur.

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Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship not established. Inform patients to consult physician before increasing dose or abruptly discontinuing this drug.

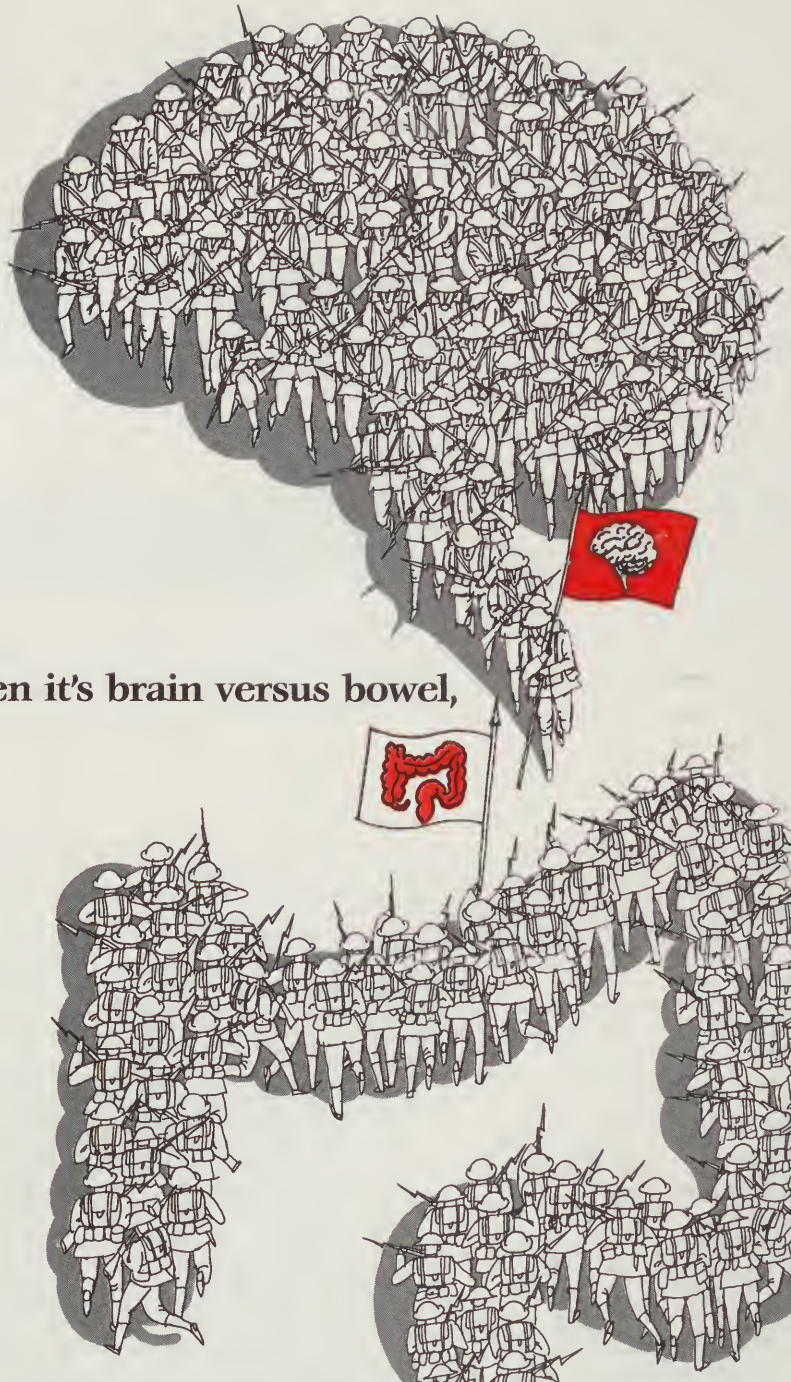
Adverse Reactions: No side effects or manifestations not seen with either compound alone reported with Librax. When chlordiazepoxide HCl is used alone, drowsiness, ataxia, confusion may occur, especially in elderly and debilitated; avoidable in most cases by proper dosage adjustment, but also occasionally observed at lower dosage ranges. Syncope reported in a few instances. Also encountered: isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent, generally controlled with dosage reduction; changes in EEG patterns may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice, hepatic dysfunction reported occasionally with chlordiazepoxide HCl, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax typical of anticholinergic agents, *i.e.*, dryness of mouth, blurring of vision, urinary hesitancy, constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.

Drug Abuse and Dependence: Withdrawal symptoms similar to those noted with barbiturates and alcohol have occurred following abrupt discontinuance of chlordiazepoxide; more severe seen after excessive doses over extended periods; milder after taking continuously at therapeutic levels for several months. After extended therapy, avoid abrupt discontinuation and taper dosage. Carefully supervise addiction-prone individuals because of predisposition to habituation and dependence.

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THE JOURNAL OF THE MEDICAL SOCIETY OF NEW JERSEY FEBRUARY 1991



Mental Illness at Elizabeth General Hospital

in the La[illegible] 19th Century

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Photographs: Top left: Elizabeth General Hospital, 1894; Middle: Outpatient Department; Bottom left: Men's Ward; and Bottom right: Women's Ward.





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NEWSWATCH

MANDATORY MEDICARE ASSIGNMENT

Mandatory assignment has become a critical issue in the Legislature. Governor Florio mentioned mandatory assignment in his State of the State Address and since that time the administration has made it the number one priority ahead of uncompensated care.

Thus far, MSNJ has avoided having the two issues linked, which is the strategy used by the administration. A fact sheet was sent to all members by the Council on Public Relations and **everyone has been requested to contact the Legislature to express physician opposition.**

NO-FAULT, COURT RULES AGAINST PROFESSION

On January 11, 1991, the Tax Court ruled against MSNJ and the State Bar Association, and declared that the $100 per year surcharge was legal. An appeal has been filed and the litigation will continue.

Meanwhile, the Supreme Court heard the insurance industry suit on January 15, 1991; that suit calls for the entire law to be invalidated. A June decision is anticipated.

HCFA DELAYS MEDICARE PAYMENTS

In mid-January 1991, HCFA notified all Part B carriers that effective February 1, 1991, all claims other than electronic claims were to be delayed 60 days. This action will devastate many physicians. MSNJ and the AMA have filed protests with the president, the Budget Office, HCFA, and Congress.

OPTOMETRIC DRUG BILL FAILS

A-743, a bill to allow optometrists to use topical medications, failed to pass in the Assembly. Forty assemblymen voted in favor of the legislation and it failed by 1 vote. The record of the vote follows:

New Jersey General Assembly: 204th Legislature

Yeas: 40
Nays: 24
Not Voting: 14

Vote	Assemblyman	Vote	Assemblyman
N	Adubato	N	Kyrillos
N	Albohn	Y	Lo Biondo
N	Arnone	Y	Marsella
N	Baer	Y	Martin
N	Brown	N	Mattison
Y	Bryant	N	Mazur
X	Bush	X	Mc Enroe
Y	Catania	Y	Mc Greevey
Y	Charles	Y	Mecca
Y	Cimino	Y	Menendez
N	Cohen	Y	Moran
N	Colburn	Y	Mullen
Y	Collins	N	Naples
N	Connors	N	Ogden
N	Cooper	Y	Otlowski
X	Crecco	X	Pascrell
Y	De Croce	Y	Patero
N	Deverin	X	Pelly
Y	Doria	X	Penn
X	Doyle	N	Randall
Y	Duch	Y	Roberts
X	Farragher	Y	Rocco
N	Felice	Y	Roma
X	Ford	Y	Rooney
Y	Franks	N	Russo
N	Frelinghuysen	Y	Salmon
Y	Garrett	Y	Scerni
Y	Gill	Y	Schluter
N	Hardwick	X	Schwartz
Y	Haytaian	X	Shinn
Y	Hudak	N	Shusted
Y	Impreveduto	Y	Smith J
Y	Jacobson	X	Smith R
X	Kalik	Y	Spadoro
Y	Kamin	N	Stuhltrager
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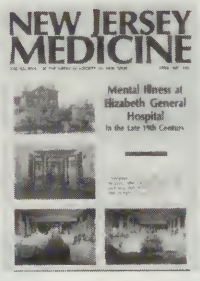
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In 1880, Elizabeth General Hospital opened its doors; records often noted case histories of psychiatric patients.
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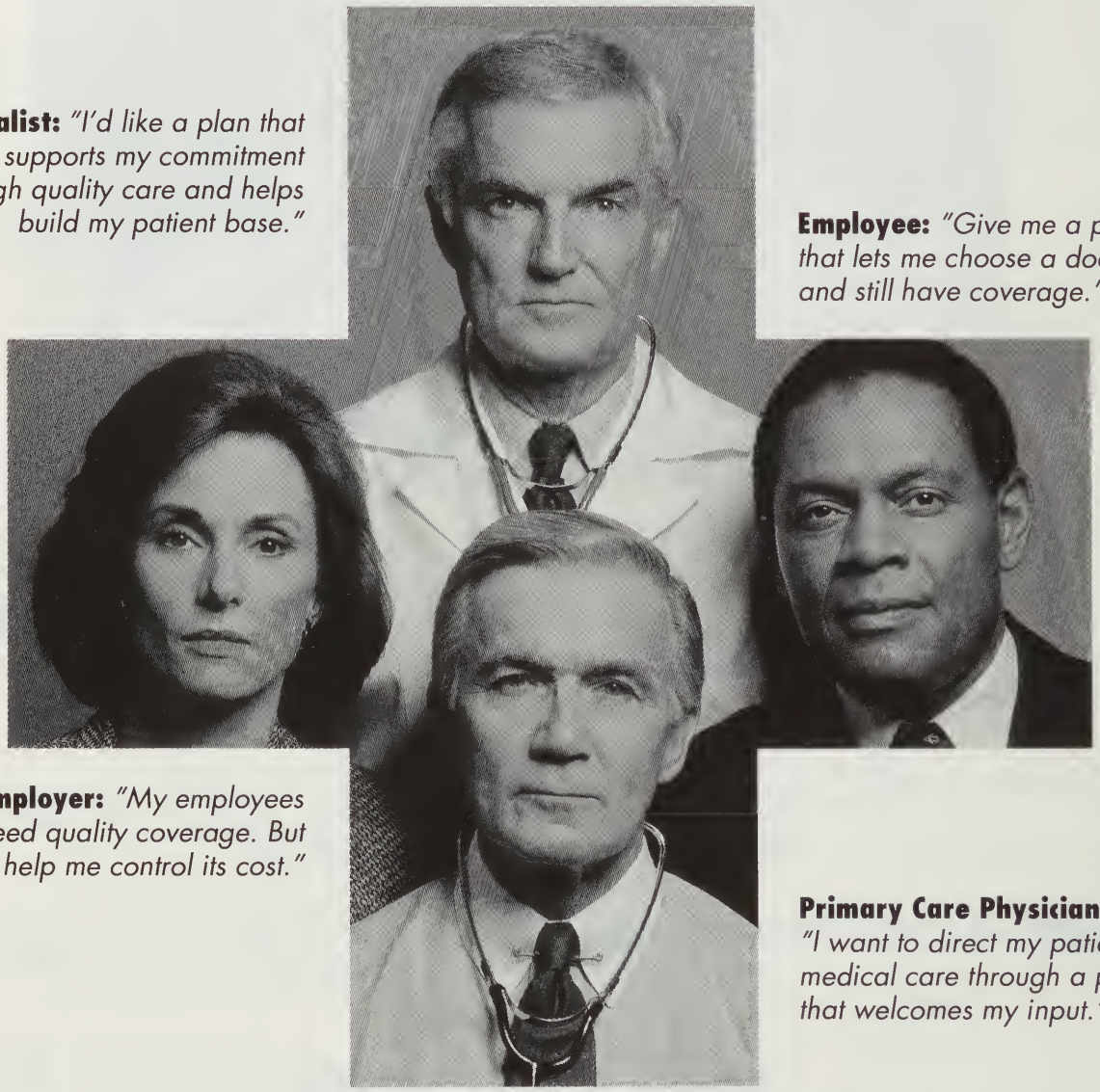
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MSNJ NEWSLETTER

MEDICARE FUNDING: WORKERS VERSUS ELDERLY

Representative Pete Stark (D-CA), House Ways and Means Health subcommittee chairman, has proposed an alternative plan to reduce Medicare spending by $30 billion during fiscal years 1991 to 1995. The plan would increase the cap on wages eligible for employer and employee FICA tax from $51,300 to $150,000. Since workers and employers each pay a 1.45 percent tax on eligible earnings, that is used to fund Medicare, Stark's proposed increase in the cap would shift the spending cut burden from the elderly through increased deductibles and premiums to workers. Current budget proposals consider raising the cap to $73,000. Stark's proposal for the tax increase is likely to be resisted by Republicans.

HOSPITAL RATES UP SHARPLY

According to recently released statistics, hospital patient rate increases in several states significantly outstripped cost increases during the same period. States with sharp rate increases during the first half of 1989 compared to the same 1988 period included Florida (17.7 percent), Pennsylvania (15.4 percent), Illinois (14 percent), and North Carolina (12.7 percent). According to providers in these states, the rate increases or cost shifts were prompted by underpayments from Medicare and Medicaid. The charge increases compare to a reported 11.4 percent growth in the cost of hospital services for the year ended July 1989 as reported by the Bureau of Labor Statistics' Consumer Price Index. Concerned about sharply increasing hospital charges, states are closely monitoring these trends, a fact evidenced by the existence of 35 state cost-containment commissions.

HOSPITAL COSTS INCREASE LESS THAN LAST YEAR

The American Hospital Association Hospital Marketbasket Index shows that the inflation rate for most hospital goods and services for the first six months of 1990 increased less than for the same period in 1989. The index reported an increase in noncapital goods and services of 7.2 percent, down from 8 percent the previous year. The labor and nonlabor components of the index were up 8.4 percent and 5.3 percent as compared to previous year rates of 9 percent and 6.1 percent, respectively. Fuel and utility prices were up 7.8 percent over 2.9 percent a year ago, without even considering the inevitable escalation attributable to the current Mideast crisis.

INSURANCE PREMIUMS MAY LEVEL

The Health Insurance Association of America (HIAA) reports health insurance premiums could stabilize and reflect more moderate growth rates over the next two years. The 1989 employer premium rate increase of a record 18 percent exceeded the 1988 increase of 12 percent and 1987's increase of 6 percent. The optimistic future rate forecast is based on an assumed insurer profitability improvement achieved through the previous year's rate increases.

MANDATED INSURANCE COULD CUT JOBS

A recent study by CONSAD Research Corporation states that mandatory employee insurance costs would have a severe impact on employers, more severe than an increase in the minimum wage. Other estimates peg the cost of universal employee coverage at a reduction of

as many as 3.5 million jobs, or a combination of job, salary, and benefits reductions affecting 5.4 million to 8.6 million workers. Universal health insurance proponents are critical of these estimates and claim minimal resulting job elimination.

NURSING HOMES UNCLEAR ABOUT OBRA

Increased nursing home patient care standards enforced through HCFA interim regulations published in February 1989 and effective on October 1, 1990, for Medicare and Medicaid patients, still contain some ambiguity and lack of clarity. Compliance with the reform regulations required by the 1987 Omnibus Budget Reconciliation Act (OBRA) would be determined by state surveyors; the industry contends the surveyors have not been given sufficient guidance for interpreting quality of care judgments. Penalties for noncompliance may include fines or reimbursement reductions. Major changes required by the regulations are estimated to add costs of $442 million in 1991 and $625 million in 1992, and include nurse's aide training, increased registered nurse staffing, and preadmission screening.

CHAMPUS MANAGED CARE

Congress has decided not to expand CHAMPUS managed care program beyond its initial test sites in California and Hawaii until at least 1992. The CHAMPUS prepared health program, run by Foundation Health Corporation covers 860,000 military dependents and retirees in California and Hawaii. According to a Rand Corporation report, CHAMPUS spending in those states remained constant last year which they attribute to the Foundation's directing of beneficiaries to military treatment facilities and reduction in inpatient psychiatric care. CHAMPUS had been seeking an expansion of its managed care program to Arizona, Nevada, and New Mexico but Congressional concerns over cost and quality of care will delay that move beyond 1991.

BLUES BENEFIT FROM UTILIZATION

According to a study conducted by the Blue Cross and Blue Shield Association (BCBSA), utilization management programs used by Blue Cross and Blue Shield plans since 1980 reduced hospital payments, admissions, and length-of-stay. The utilization management programs included preadmission certification, concurrent review, retrospective review with denial of payment, and case management. The BCBSA study indicated that the four programs reduced hospital payments by $53 per patient, admissions by 20 percent, and length-of-stay by approximately 25 percent in 1988.

HCFA FOCUSING ON MANAGED CARE

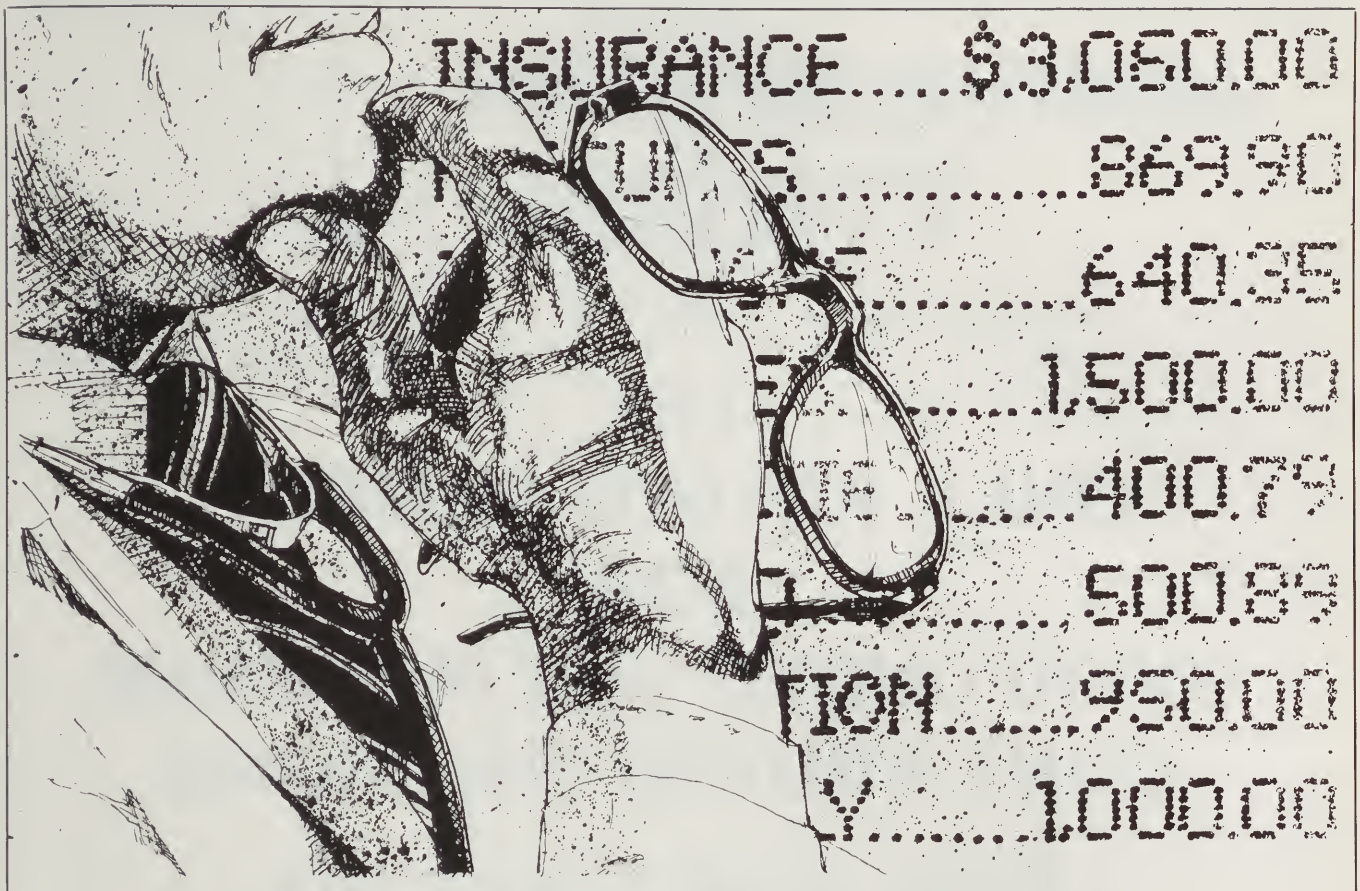
HCFA Administrator Gail Wilensky is looking toward intensifying Medicare's managed care program as a means of controlling rising costs. According to Wilensky, Part B spending is rising due to increased utilization not price increases. Enrollment in Medicare managed care programs grew only by 1.8 percent this past year. During 1990, 10 plans dropped out of the Medicare risk contract program and 12 plans signed up to participate. Concerns over the adjusted average per capita costs (AAPCC) payment methodology appear to be the primary cause for HMOs dropping out of the Medicare risk contract program.

HCFA CUTS CALIFORNIA SUPPORT

HCFA has reduced California's first quarter Medicare and Medicaid survey and certification funding by $5 million due to the state's failure to adopt and enforce federal nursing home reforms effective October 1, 1990, under OBRA 1987 requirements. California's MediCal officials have been requesting exemption from the reform on the basis that existing state requirements are more stringent. HCFA has rejected California's state plan and plans not to exempt California from the reform.

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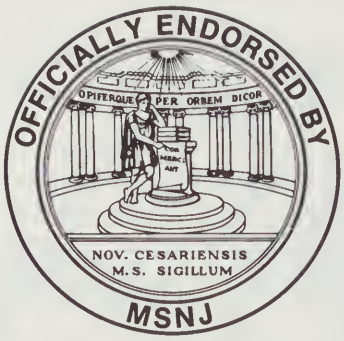
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PROFESSIONAL LIABILITY

PRIVACY RIGHTS OF FAMILY OF AIDS VICTIM

A police officer violated the privacy rights of a man who had AIDS when they disclosed it publicly, a federal trial court for New Jersey ruled. The police officer arrested the man and impounded his pickup truck. He was arrested on charges of unlawful possession of a hypodermic needle and an outstanding burglary warrant. When he was arrested, he told the police officers he had tested HIV positive and they should be careful in searching him because he had "weeping lesions." That day, one of the officers told two other officers the patient had AIDS. One of the officers then told one of the man's neighbors that he had AIDS. She became upset and contacted the school her daughter attended, other parents with children in the same school, and the media. As a result, 19 children were removed from the school the next day due to a panic over the man's children attending the school. The man and his family alleged that they suffered harassment, discrimination, and humiliation. They claimed they were shunned by the community. The trial court found that the police violated family members' privacy rights by disclosing the fact the man had AIDS. The employer of the policemen violated their privacy rights by failing to adequately train officers about AIDS, the court said. (Reprinted with permission from *The Citation,* American Medical Association, Volume 61, September 1, 1990.)

HOSPITAL PATIENT WHO SWALLOWED BLEACH AWARDED DAMAGES

An award of $55,000 in general damages for a patient who consumed bleach from a plastic cup inadvertently placed on his hospital meal tray was excessive, a Louisiana appellate court ruled. The patient was hospitalized for treatment of back problems related to a worker's compensation claim. When he sipped what was supposed to be white wine, his mouth and throat immediately began burning, and he could not breathe. After he vomited and started breathing, the patient asked cleaning personnel to get help for him.

The hospital made a preliminary determination that the substance was bleach and contacted a poison control center for recommended treatment. An emergency room physician and the patient's treating physician were notified, and the patient was advised that the hospital would provide medical treatment for any problem associated with the bleach ingestion. The patient was given cortisone and an antibiotic and monitored for the rest of the day.

The patient's treating physician examined the patient that night, but found nothing of significance. An ear, nose, and throat specialist who examined the patient the next day also found no abnormalities.

The patient saw a succession of physicians, none of whom testified at trial. According to the patient's wife, one physician, a gastroenterologist, found that the patient had a hiatal hernia. An otolaryngologist subsequently made the same diagnosis. An expert in psychiatry and neurology found that the patient was depressed and had a fear of cancer because of persistent swallowing difficulty. He prescribed a tranquilizer for the patient.

In a suit against the hospital, the patient contended that the liquid he swallowed was lye. However, an expert in forensic chemistry who examined the container, after thoroughly testing the residue in the plastic cup, ruled out that possibility and gave the opinion that the substance was bleach. The patient presented no chemical evidence to the contrary. This finding was supported by medical evidence that if lye had been ingested there would have been a narrowing of the esophagus, caused by scar tissue. There also was medical opinion that the ingestion of bleach could not have caused the hiatal hernia.

The jury awarded the patient $55,000 in general damages ($20,000 for physical pain and suffering and $35,000 for mental pain and suffering) and $5,000 for medical expenses. On appeal by the hospital, the appellate court could not find that the severity of duration of the patient's injuries justified the $55,000 award. On the basis of the evidence presented, the court found that the highest amount awardable to the patient was $27,500. The court also agreed with the hospital that the award for medical expenses was not justified. The unpaid medical expenses were stipulated to be $2,777.95. Therefore, the court reduced the medical expenses to the amount of the unpaid medical expenses. (Reprinted with permission from *The Citation,* American Medical Association, Volume 61, August 15, 1990.)

CHILD NEGLECT PROCEEDING BROUGHT AGAINST MOTHER WHO TOOK DRUGS

A mother's testing positive for cocaine, among other things, established a prima facie case of child neglect, a New York appellate court ruled. A neglect proceeding was brought in which it was alleged that the mother's three children were neglected by her misuse of drugs. A social worker was the only person to testify, and a hospital record of suspected abuse or maltreatment was introduced.

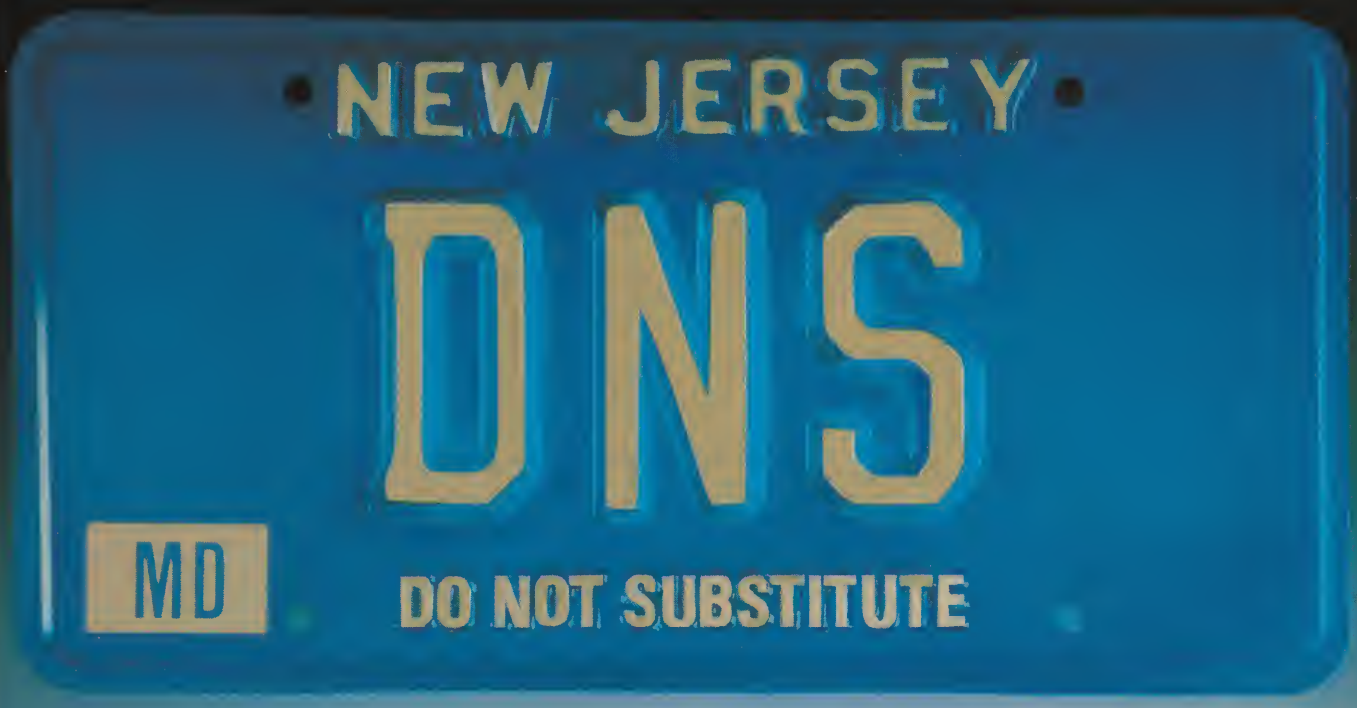
Evidence revealed that while the mother was in the hospital to have one of the children, she tested positive for cocaine. The baby was born prematurely, had renal failure, and died, and therefore no urine could be collected from her in order to test for addiction. The mother admitted to the use of cocaine once in a while, including the night before the baby's birth. She also told the social worker that she was not in a drug treatment program but was amenable to entering one.

The trial court granted a motion to dismiss for failure to make out a prima facie case. On appeal, the appellate court said that the positive testing for cocaine, the admitted drug use, the proximity of drug use to the premature birth, and the mother's willingness to enter a treatment program established a prima facie case of neglect. Further, there was an indication in the record that since the filing of the neglect petition, the mother might have been arrested for drug possession. The court sent the case back for a continued fact-finding hearing. (Reprinted with permission from *The Citation*, American Medical Association, Volume 61, August 15, 1990.)

PROFESSIONAL LIABILITY

James E. George, MD, JD, is director of the Department of Professional Liability Control, Medical Society of New Jersey, and A. Ronald Rouse is director of Special Projects, Medical Society of New Jersey.

Please address all comments and concerns to A. Ronald Rouse, Director of Special Projects, Medical Society of New Jersey, Two Princess Road, Lawrenceville, NJ 08648. Mr. Rouse also can be reached by calling 609/896-1766, at Medical Society of New Jersey headquarters in Lawrenceville.

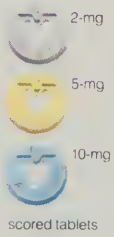


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EDITOR'S DESK

HMOs TODAY

Health maintenance organizations (HMOs) have been pets of the federal government for years, enjoying perks ranging from cash subsidies to regulatory favoritism and preference, raising the hackles of those competing in the rendering of health care services, who decry such practices as unfair competition. Yet, the financial viability of HMOs has been a mixed bag. Some have been profitable; others have lost money; some have declared bankruptcy, including one of the largest, Maxicare, which now has reorganized. It will be interesting to note how HMOs fare in the next five to ten years while competition grows between them, the government, other managed health care programs, and the private, fee-for-service sector.

HMOs developed from the concept that health care could be delivered less expensively if fat could be removed from the system; if unnecessary testing and treatment were eliminated; and if hospitals and practitioners could be held to contractual limits. The patient (subscriber) would receive mixed benefits: there would be minimal out-of-pocket expense, but the choice of physician or of hospital would be restricted and the HMO could bestow or withhold elements of care. Management would be simple. Good controls, careful financial assessments, and proper selection of the deliverers of care would lead to success in cutting costs. Additionally, HMOs would emphasize preventive medicine to decrease acute care medical costs—an ounce of prevention being worth more than a pound of cure. And everyone would benefit.

But something happened to interrupt the anticipated swell in the enrollment, and health care costs did not lend themselves to the controls as anticipated. Recent years have highlighted the unprofitability of HMOs, including those in New Jersey. More of them lost money in 1989 than showed a positive balance, according to the New Jersey State Department of Insurance. Much of the problem was ascribed to poor financial planning, especially by those organizations attempting to maximize their market shares in the face of increasing numbers of competing groups, sometimes by offering unrealistically low rates. Part of the problem, undoubtedly, is related to the unreasonable reliance on the "ounce of prevention" philosophy, a foolishness shared by too many individuals and groups who impact the health care scene. It never has been shown that the health of a subscribing population has been improved measurably by covering more preventive services. It has been shown that the most effective preventive measures relate to changes in lifestyles, societal changes that the medical profession can influence only tangentially and marginally. True preventive health activities can be obtained by individual initiative and responsibility regarding self-pollution, by improving such basics as nutrition and housing and by maintaining a safe environment for work, play, and sleep.

The outlook for HMOs, and perhaps for other types of managed care, is difficult to predict, even in our home state. The financial losses of the last few years have stimulated much reorganization. Some smaller

plans have folded; others are restructuring; others propose mergers; and, large insurance groups are gobbling up some of the remainder.

Some of us who were involved intimately in the actual process of establishing an HMO, nurturing it, supervising its growth and, ultimately, also recognizing the changes it produced in traditional medical practice, perforce, must harbor some reservations. We were taught that new ventures could succeed, as previously noted, if fat was in the system. The fat was there for the rendering initially; the system is much, much leaner today. Can HMOs, or any similar plan, be successful and help to control health care costs without further rationing of care to the patient and without further slashing of reimbursement to the physician and to areas of patient care? If proper health care is a basic right of the American citizen, if those who dedicate their lives to providing that care are to be regulated more and more, is it ethical or proper for those who merely distribute the funds to make a profit? Is capitalism a one-way street? Are the times ripe for "caveat venditor"? □

> *Insurance,* n. An ingenious modern game of chance in which the player is permitted to enjoy the comfortable conviction that he is beating the man who keeps the table.
>
> Ambrose Bierce, *The Devil's Dictionary* (1881-1911)

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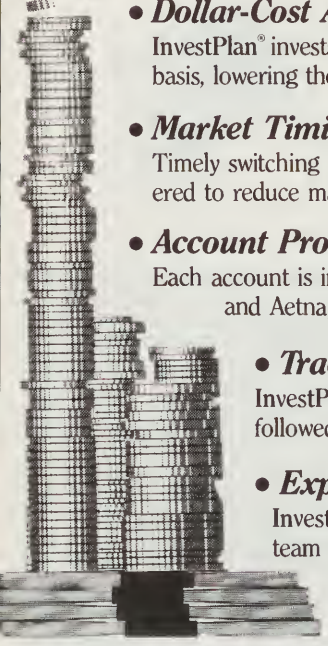
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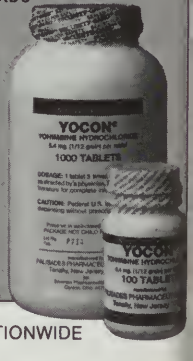
Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.[1,3,4] 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to ½ tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.[3]

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References:

1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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BOOK REVIEWS

COMPUTED TOMOGRAPHY OF THE BODY

John Haaga and Ralph J. Alfidi (eds). St. Louis, MO, Mosby-Year Book, 1990. This second edition of the popular two-volume encyclopedic review incorporates the use of high-resolution, fourth-generation computed tomography (CT) scanning images and power contrast injector techniques. This update completes a highly extensive and sophisticated treatment of the field. Each organ system is considered with the utmost detail, and ample displays of high-quality images enhance the text.

The sections of the first volume are devoted mainly to CT of the central nervous system. The chapters include discussions of congenital anomalies, tumors, trauma, and demyelinating diseases. The complexities of the skull base are skillfully handled, with attention given to the orbit and sella. The second volume addresses all areas of body imaging from the thorax and heart to the pelvis. The commentary on the lungs encompasses such topical subjects as differentiation between benign and malignant lung nodules. Diagnosis of entities such as hemangiomas, focal nodular hyperplasia, and adenomas highlights the chapter on the liver. Of particular note are the lucent articles covering the pancreas, adrenal glands, and kidneys. With the growing reliance on CT to diagnose disorders of the musculoskeletal system, the emphasis on CT staging in the section on osseous malignancies hits the mark. This area receives less attention in the book than other parts. Nonetheless, each chapter is quite complete in its probing of each organ system. In addition, pediatric imaging and biopsy techniques are explored.

The editors have compiled a broad and readable selection for the interested physician. The text is a highly worthwhile investment. □ Neil B. Horner, MD

IMMUNOLOGIC DISORDERS: IN INFANTS AND CHILDREN, 3RD EDITION

E. Richard Stiehm, MD. W.B. Saunders Company, Philadelphia, PA, 1989. This hardcovered text is an extensive compilation of papers by well-renowned clinicians and "clinician-scientists." The text focuses on those immunological disorders affecting neonates, children, and adolescents. The book contains a tremendous amount of information on the various immunological problems encountered—traveling through the basic science with clinical relevance to the most common immunological assays ordered by the clinician. The text is divided into three parts: Part I is dedicated to the development and function of the immune system; Part II covers immunodeficiency disorders; and Part III deals with the immunologic aspects of pediatric illnesses. In Part II, a chapter is dedicated to the unique immunodeficiency problems associated with mucosal antibody deficiencies including IgE and IgA while Part III reviews organ system immunology and specific pediatric disorders, e.g. infectious mononucleosis, immunizations transplantation. The text is an excellent choice to compliment those found for the generalist in charge of the care of adults and pediatric patients. □ Leonard Bielory, MD

IMMUNOINTERVENTION: AUTOIMMUNE DISEASES

J.F. Bach. San Diego, CA, Academic Press, 1989. This softcover text is a compilation of papers and lectures given at an international meeting in Paris, France, in June 1988. The meeting focused on the issues of the

"primary" pathogenetic mechanisms of autoimmune disorders with the intent of developing strategic treatment plans. The individual papers range from a superficial overview of the topic to a detailed analysis of specific animal models supporting the hypotheses stated. The authors do address the clinical use of immunomodulatory agents for a variety of organ specific and systemic autoimmune disorders, e.g. systemic lupus erythematosus, polymyositis, rheumatoid arthritis, type I (insulin dependent) diabetes. The book is a primary text for the "basic science"-inclined clinician. It lives up to the editor's goal as a record of the 1988 international meeting. ☐ Leonard Bielory, MD

IMMUNOPHYSIOLOGY: THE ROLE OF CELLS AND CYTOKINES IN IMMUNITY AND INFLAMMATION

Joost J. Oppenheim, MD, and Ethan M. Shevach, MD (eds). New York, NY, Oxford University Press, 1990. Immunophysiology is a new name for a growing area of immunology. This book is extremely unique in summarizing the recent progress in the mechanisms of host defenses. There are 23 chapters totaling 405 pages edited by a national array of who's who in cytokine and inflammation research. The text places a new focus on the immune system and its interaction with tissue and cells that are not considered part of the immune system. The text is well written and highlights important aspects of cytokine research in an expanding subspecialty of immunology. A major portion of the text is dedicated to the effects of the mediators of activated immunocytes, i.e. cytokines, lymphokines, monokines, on noninflammatory cells including the connective tissue and neuroendocrine system, as well as the interaction of the neuroendocrine system's release of growth factors on the immune system. Several chapters highlight the inflammatory consequence of endotoxins, complement, immune complexes, and the immunomodulatory effect of a variety of growth factors. I highly recommend this book for clinical researchers interested in cytokine and inflammation research. ☐ Leonard Bielory, MD

OCULAR PATHOLOGY: A TEXT AND ATLAS

Myron Yanoff, MD, and Ben S. Fine, MD. Philadelphia, PA, J.B. Lippincott Company, 1989. This is the third edition of a text covering the field of ophthalmic pathology in considerable detail. The authors state an attempt was made to shorten this third edition relative to the second edition since there are longer and more comprehensive texts on ophthalmic pathology. This book will remain the standard for residents in ophthalmology and ophthalmic pathology. As in the previous editions, clinical photographs and radiographs enhance the pathophysiologic approach of the text. This book serves as a companion to *Ocular Pathology: A Color Atlas.*

Despite this shorter rendition, the sections on immunopathology, complications of intraocular lens implantation, corneal dystrophies, and genetics of retinoblastoma have been extensively revised. Drs. Yanoff and Fine are to be congratulated for their excellent contribution. While none of the sections will stand as a definitive work, the text will serve as a source of information and certainly a starting point for any reference work in ophthalmic pathology. ☐ Joseph A. Mauriello, Jr., MD

PSYCHIATRIC DICTIONARY

Robert J. Campbell, MD. New York, NY, Oxford University Press, 1989. Dr. Campbell has been responsible for recent editions of this excellent dictionary; the first edition was published in 1940 by Hinsie and Shatzky. Over the past eight years, psychiatry has developed in many directions, and the dictionary has grown to encompass a wide variety of terms and abbreviations. Thus, in this sixth edition, one may find DRG, DSA (digital subtraction angiography), DSM-III-R *(Diagnostic and Statistical Manual),* DST (dexamethasone suppression test), duty

to warn, dying (stages of), and dymorphins. There are lists of hundreds of phobias and manias, scores of reflexes, pages of different types of delusions, and syndromes from angry woman, body-packer, Chubby Puffer, and Cinderella to Happy Puppet and Othello. This volume should be readily available to every physician for reference; it also is a fascinating book for browsing. It is without any doubt the best one-volume psychiatric dictionary. □ A. Arthur Sugerman, MD

SIR JAMES PAGET. THE RISE OF CLINICAL SURGERY

Shirley Roberts. London, England, Royal Society of Medicine, 1989. Illustrated. Paget achieved immortality by having his name associated with two diseases: osteitis deformans and carcinoma of the nipple. With far-reaching intellect and an inordinate capacity for hard work, he contributed to medicine in many ways, e.g. his efforts as examiner for the East India Company led to reforms in British medical education. But Paget was fallible too. Slow to appreciate Lister's concept of antisepsis, he almost died from an infection acquired at autopsy.

A modern biography of Paget was long overdue, the last being published in 1901. Roberts rectified this situation with a readable volume that skillfully integrates Paget's life and achievements with the medical and social milieu of his time. His honesty and noble character are tenderly revealed. Despite financial hardship during his life, Paget repaid his deceased father's debts; he even hunted out a debtor who had never pressed for payment.

My major disappointment lies in Roberts's timeworn account of Paget's discovery of *Trichinella spiralis*. The author appears unaware of recent research (Campbell W: *Bull Hist Med 53*: 520-552, 1979) exposing Richard Owen's shameless exploitation of Paget's situation as a first-year medical student in claiming the discovery for himself. Consequently, we learn nothing of Paget's true feelings about having to share his success with Owen. Notwithstanding, the book is valuable not only for its treatment of Paget, but also for its description of 19th-century medicine. □ Vincent J. Cirillo

TEXTBOOK OF CHILD NEUROLOGY

John H. Menkes, MD. Philadelphia, PA, Lea & Febiger, 1990. A fourth edition of this long-popular comprehensive text on the neurologic disorders of infancy and childhood is available. Since the first edition was published 16 years ago, many significant discoveries have occurred in the fields of molecular biology, chromosomal abnormalities, hereditary disorders, and neonatal neurologic care. This edition updates our knowledge of a wide spectrum of pediatric neurologic conditions. The first chapter deals with the neurologic examination of infants and children and should be a useful guide to medical students and residents.

This large text of 800 pages is very well written in easily readable style. Topics are well organized and nicely illustrated with tables, patient photographs, diagrams, and microscopic sections. Descriptions of each disease entity are quite detailed, with strong emphasis on the clinical aspects. Considerable attention also is paid to the basic science aspects of the multitude of neurologic disorders considered. The authors have provided an unusually complete reference list for each chapter. Notations often are provided in the text material indicating where more extensive considerations of a particular topic can be found.

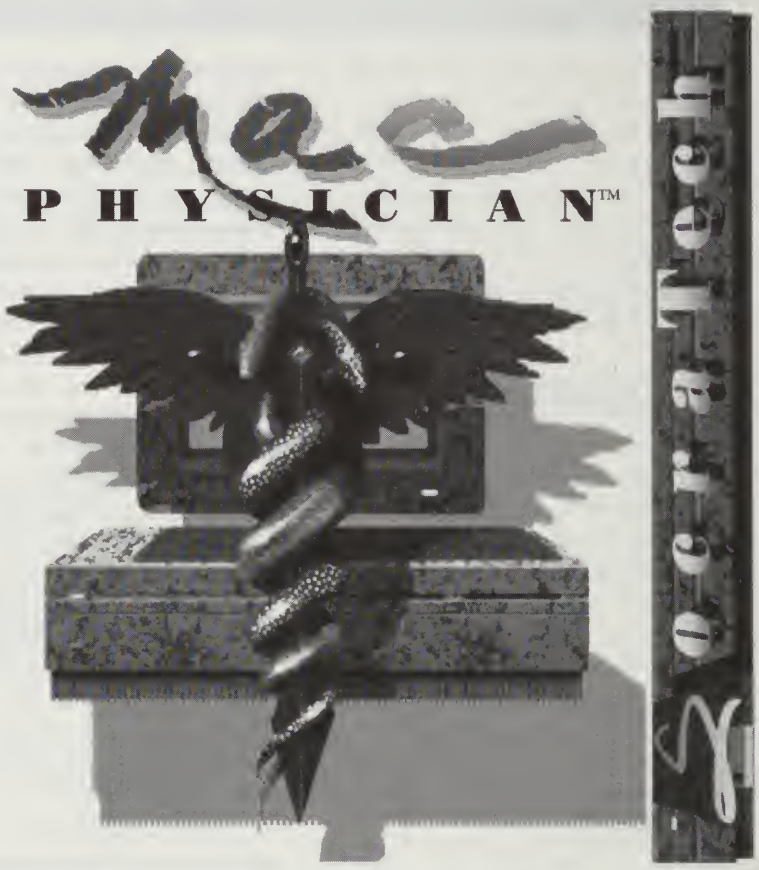
This excellent book should serve as a most useful reference for general pediatricians. It will be a basic text for those studying child neurology, and a welcome addition to the library of any pediatric neurologist. □ Stanley C. Leonberg, Jr, MD

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Mental Illness in the Late 19th Century

at Elizabeth General Hospital

L.D. HANKOFF, MD

In 1880, Elizabeth General Hospital and Dispensary opened its doors. The Hospital records, the daily newspapers of Elizabeth, and the medical journals often noted psychiatric symptomatology and concepts.

In a renovated house on Jaques Street, Elizabeth General Hospital and Dispensary (Figure 1) began receiving patients in November 1880; the staff made a preliminary statement of clinical activities as of May 24, 1881. Among the first 32 "indoor patients" was a case of neurasthenia, the first psychiatric patient in the hospital.

A wide range of psychiatric diagnoses appear in the Hospital's annual reports. In the 1880s, one or two cases of hysteria and melancholia are recorded annually. Neurasthenia was the most common psychiatric diagnosis throughout the first quarter century of the Hospital. In the 1890s, additional diagnostic terms appear in the records: dementia, mania, and confusional insanity. The broader range of psychiatric diagnoses points to the refinement in understanding and perception of psychiatric disorders in the growing institution. The 1901 annual report statistics present a more structured psychiatric categorization and divides functional dementia into five subcategories: alcoholic, praecox, periodic, traumatic, and senile. Dementia used in this classification appears to have been the designation for a major or psychotic disorder in contrast to a minor or neurotic disorder such as neurasthenia or hysteria. Other diagnoses are recorded that at a

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Figure 1. Elizabeth General Hospital and Dispensary on Jaques Street in 1880.

distance of a century cannot be conclusively defined as psychiatric ones. Senility appears as a diagnosis distinct from senile dementia. In 1881, the label of "old age" was applied to two admissions but never thereafter. Other uncertain diagnoses were marasmus, marasmus senilis, starvation, inanition, and exhaustion, each accounting for a few cases. One patient, admitted to the Hospital in 1900, had insomnia.

Treatment results sometimes were tabulated in annual reports and patient deaths with the following psychiatric diagnoses are listed: acute alcoholism, delirium tremens, and Bell's mania. The latter disorder has been described as an acute catatonic excitement that may enter a state of exhaustion, dehydration, and fever.

The outpatient clinics sometimes listed diagnoses in annual reports after 1900. Among outpatient reports are found diagnoses of alcoholism and neurasthenia. The otolaryngology clinic reported a case of hysterical deafness in its 1905 report.

ALCOHOL AND DRUGS

The ancient ill of drunkenness was increasingly viewed as a medical issue in the late 19th century. Patent medicine cures for alcoholism were advertised in the daily press with broad claims for the particular concoctions. Dependence on morphine, opium, and laudanum were well known and attracted similar treatments. The *Elizabeth Daily Journal* regularly advertised Dr. Haines Golden Specific as a proved cure for drunkenness (November 30, 1889). While the medical aspects of alcohol and substance abuse were appreciated, public drunkenness was prosecuted and cases routinely reported in the newspapers. The sinful aspect of such habits was condemned publicly.

Alcoholism and drug dependence diagnoses appear in the first complete annual report of the new Hospital in 1882 and thereafter throughout the years with increasing frequency. The substance abusing patients usually were admitted as a consequence of other surgical or medical conditions. A small number were admitted for a primary substance abuse condition under the diagnoses of alcoholism, acute or chronic, delirium tremens, and opium or morphine habit. The Hospital's involvement with those conditions was a reluctant one. For example, at one discussion, the Visiting Committee of the Board of Managers called attention "to the patient Buckholz under treatment as an opium eater who occasioned much anxiety to matron and nurses" by asking patients to purchase opium for his use. He manifested dangerous tendencies from time to time and the Board concluded he was not "such a patient as could safely be treated on the ward." The Visiting Committee was directed to take such action as deemed advisable (April 8, 1889).

The 20-bed Jaques Street Hospital obviously was not a convenient setting for difficult management problems. The Board noted among the pay patients was a case of delirium tremens that had "given much trouble and clearly showed the inability of the Hospital to take charge of such cases" (August 10, 1891). In 1894, the opening of the new building afforded an opportunity for more controlled care of addicted patients (Figure 2). The modest but significant commitment was noted by the Board on December 10, 1894, when the Committee on Grounds and Buildings reported "a room in the basement had been fitted up for delirium tremen (sic) cases."

Along with its troublesome abusers, alcoholic beverages in the Hospital were a major security concern. The Board ruled that such beverages not be

furnished to patients "except where necessary as a medicine" (May 13, 1901). The cook was reprimanded for sampling the hospital supply of spirits. A charge of stealing liquor from the drug room led to the arrest of the night watchman (June 11, 1906) who also was charged with other thefts about the Hospital. A more troubling issue occurred on March 19, 1909, when the house physician riding in the ambulance with a patient had it stop at the Kenilworth Inn for his "partaking of a meal and three or four drinks." He was reprimanded in the strongest terms, "as his course was not only an injury to the Hospital, but a reflection on its management" (April 26, 1909).

CLINICAL CONCERNS

The diagnosis and treatment of mental disorders and nervous symptoms were of some interest to the Hospital's physicians. Much of the concern of the Hospital's physicians and surgeons centered on distinguishing the subjective and psychological symptoms of disease and trauma from the symptoms of primary physical disorders. Many cases of trauma were seen in the Hospital as a result of railroad and other accidents. At the Clinical Society meeting of May 21, 1901, Dr. Grier read a paper on traumatic neurasthenia and a lively discussion followed on the effects of physical trauma "in the production of traumatic neuroses." Dr. Wilson described a Pullman conductor who was unrelieved of his back pain despite all treatment. After two years, he continued to complain of a "nervous condition" and was upset by slight noises. Dr. Bailey stated it is a mistake to assume there is no organic injury in these cases. Dr. Pettit attributed significance to fright and suddenness of injury in the production of traumatic neurosis. Dr. Grier noted that railway surgeons believe these cases do get well while neurologists are pessimistic.

The assessment of psychological symptoms in the traumatized patient must have proved frustrating to the physicians and surgeons of the new Hospital and occasionally a patient was concluded to be malingering. This diagnosis appears on the average once a year in the inpatient diagnostic records of the Hospital. On the national scene, an accusation of feigned insanity played a significant role in the sensational trial of Mrs. Lizzie Halliday accused of several fiendish murders. As reported in the *Elizabeth Daily Journal* (June 21, 1894) at least six psychiatrists testified regarding her obscene and violent behavior. The defense presented Dr. Edward C. Mann of the Flatbush Insane Asylum, Dr. Talcott of the Middletown Asylum, and Dr. H. E. Allison, superintendent of the Mattewan Hospital, all of whom attested to her insanity. The prosecution called Dr. Beaks of Bloomingsburg, Dr. William H. Woodruf of Pine Bluff, and Dr. James A. Caruthers of Monticello, all of whom concluded that she was feigning insanity. She subsequently was found guilty of murder in the first degree by the jury.

The involvement of the Hospital with psychiatric problems and substance abuse probably was an uneasy truce. In the new 1894 quarters, the delirium tremens patients were consigned to the basement and hopefully out of sight. Patients without evident somatic disease or injury but psychologically disabled or subjectively symptomatic challenged the diagnostic skill of the physician. When a choice arose, however, to have greater exposure to the mentally ill, the medical staff expressed its preference unambiguously. Thus, at the October 1899 meeting, the Clinical Society conveyed "to the Board of Freeholders of Union County its unanimous opposition to the construction of a county hospital for the insane." Did the medical staff want to assure itself a healthy distance from serious psychiatric patients? Were the physicians and surgeons of the Hospital wary of the possibility that the county hospital for the insane might need acute medical care for its patients?

HYPNOSIS

By the end of the 19th century, hypnosis had moved through a tortuous historical past to become regarded as a serious treatment approach. The staff at Elizabeth General Hospital was interested in the healing power of hypnosis. At the Clinical Society's 52nd meeting on May 16, 1899, arrangements were made for a Mr. Meecham to give a practical demonstration of hypnotism. American physicians building on European experience offered their own clinical findings. Hypnosis was described as useful in the treatment of inebriety.[1,2] The scientific value of hypnosis was presented to the readers of the *Elizabeth Daily Journal* (January 7, 1881) in a description of the successful experiments of Dr. George M. Beard: "It is a great advance to find that this class of experiments is thus beginning to be conducted by scientific men."

SUICIDE

Suicide was given considerable attention in the *Elizabeth Daily Journal,* with mention of the Hospital and its physicians involved in the care of suicidal patients. The newspaper reports often were given with dramatic and vivid detail, motivations cited, and conclusions freely offered.

In Elizabeth, a 22-year-old man having lost his job at Singers because of "the dull time" swallowed Paris green (arsenic) and was seen by Dr. Mack who ordered the patient removed to the Hospital by ambulance. There had been a trivial quarrel between him and his father and when he became sick in the



Figure 2. Newspaper drawing of the new buildings of Elizabeth General Hospital and Dispensary and Blake Memorial in 1894.

afternoon the doctor was called. "The sick man denies stoutly having taken anything with suicidal intent . . . . His parents, however, assert their belief that their son took the poisonous dose while in a fit of despondency." The patient was doing well in the hospital subsequently (March 30, 1894). This suicide attempt might be regarded as Elizabeth's casualty from the financial crash of 1893 and the ensuing economic depression.

A hardware merchant of Union Square took his life with a revolver. Drs. Terrill, Mravlag, and Grier were summoned but there was little they could do for the wounded man. The act was attributed to a quarrel that had occurred between the dead man and a family member (September 17, 1894).

The Hospital records of diagnoses do not have a category of suicide but do list specific poisonings. Deliberate self-injurious attempts probably were associated with most of the listed poisonings from carbolic acid, kresolin, arsenic, hydrochloric acid, antimony, ammonia, iodine, sulfuric acid, oxalic acid, and chloral. The substances of abuse (cocaine, opium, and morphine) are listed among the causes of poisoning while there are separate diagnostic categories for morphine habit and opium habit. A single gunshot wound to the brain is listed although we cannot be certain that this was a suicide. Illuminating gas is listed as a cause of poisoning in a considerable number of cases: 24 cases over the period of three decades and may have been deliberate self-injury in some cases. In the first decade of the 20th century, poisonings accounted for nearly 1 percent of the total hospital admissions.

MEDICAL IDEOLOGIES

The late 19th century was a period of medical contrasts. Objective methods for medical diagnoses were being developed and the leadership in medicine prided itself on a new era of scientific medicine.[3] "Everywhere science with the microscope and the crucible is following the germs of disease and the agencies of death."[4] The other side of the story was the appeal to the public by unprincipled exploiters.

Quack cures and exaggerated claims abounded. The press and pamphlets advanced all sorts of cures for diseases in the most persuasive and attention-getting manner possible. In particular, the claims of cures of the unsubstantiated and frankly dishonest were tied to advances in the physical and chemical sciences of the day. Electrical, mechanical, and radiological methods were given as selling points for quack cures. For example, radio-sulpho brew was a blood purifier and tonic to be used both internally and externally.[5] Professor Thomas F. Adkin was advertised as a miracle healer with supernatural powers, and possessing the key to the fountain of youth. His technique of vitaopathy was based on "a subtle force of nature, regulating the intellectual and spiritual being which controls the physical man." An American College of Mechano-Therapy offered a diploma in suggestive therapeutics at the completion of a course of mental science. A device entitled the electropoise offered an oxygen home remedy without medicine and caused "the negative elements so abundant in the atmosphere to be attracted into the body in sufficient quantity to consume the accumulation of combustible matter stored up by the imperfect action of the vital organs." A news item in the *Journal of the American Medical Association (JAMA)* described the exposure of one notorious quack, Professor Ernest De Blanc, through the investigative reporting of newspaper reporter, Miss Nellie Bly (December 15, 1888). She exposed his electrical treatment as based on fakery and revealed the details of his many fraudulent claims.

The readers of the *Elizabeth Daily Journal* were informed of Parker's ginger tonic for the consumptive, and the sufferer from "cough, bronchitis, asthma, indigestion . . . . It has cured the worst cases and is the best remedy for all ills arising from defective nutrition," while Ely's catarrh cream balm "cures cold in head, catarrh, rose cold, hay fever, deafness" and "restores the sense of taste and smell" (November 1, 1890).

Much of the advertisement for cures played on the theme of the vulnerability and fragility of women. "Female weaknesses are more common today than ever before. It is the mode of living: constant work and worry weaken the nerves and vitality and female weakness follows. They are delicate and cannot stand the strain" (December 1, 1894). The recommended cure was Dr. Green's nervura blood and nerve remedy.

The frailty of women was established medical doctrine of the time. The great neurologist and innovator, S. Weir Mitchell, advanced his rest cure for neurasthenia and other conditions of "nervous exhaustion." It was particularly useful for women over-

whelmed by a large family and a self-centered husband.[6]

In the late 1800s, surgical approaches to the chronic debilitated female patient were developed. A *JAMA* report of Society proceedings describes a 33-year-old woman suffering nearly two decades from dysmenorrhea and intense pain in both ovaries who was a confirmed masturbator (April 16, 1887). Dr. E.W. Cummings noted her "state of profound melancholia on account of the belief that she had committed the unpardonable sin, and was eternally damned." She begged for surgical assistance and was operated on by E.W. Cushing who removed both ovaries. "Since the operation she has been entirely free from melancholia and sexual passion. She describes her mental condition by saying 'a window has been opened in heaven.' Some scoff at the idea that insanity can be favorably influenced, in any case, by removal of the ovaries, but the operation has been done repeatedly and with a degree of success sufficient to prove that ovarian trouble can cause mental derangement." There was considerable discussion at this presentation including the question of a corresponding operation for a similar condition in a man. Dr. Warner reported a case in which the clitoris and all tissues down to the pubic bone were removed and stated he was opposed to all such operations and "believed the favorable results reported came from the powerful moral influence of the operation." Dr. W. Symington Brown raised a number of questions. "He believed if nymphomania was a disease of any one organ, it was a disease of the brain and not of the ovaries. On this theory any shock may cause an improvement, whether it is purely moral or the effect of a radical operation." At a followup meeting, Dr. Cushing noted that his patient is "still entirely free from mental derangement and excessive sexual passion."

In the last decades of the 19th century the realm of psychological intervention was claimed by many quacks and mental healers. In contrast, practicing physicians who identified with the scientific principles of the profession, had limited tools and experience in psychological care. S. Weir Mitchell's rest cure, despite its bold rhetoric, added little to the recuperative means prescribed by experienced physicians. Other medical methods, e.g. ovariectomy, purging, perhaps sincerely based were indistinguishable from quack remedies. To this confused picture was added the American religious tradition of faith healing. This tradition was radicalized by the birth of the Christian Science church. The church had its beginnings in 1886 when its founder Mrs. Mary Baker Eddy discovered, as she described it, the divine science of Christian healing. In 1875, she published the first edition of her book on the subject, "Science and Health." Her following and church organization grew rapidly and obtained international stature by the end of the century. The Christian Science Church offered healing through its faith, declaring disease to be an illusion. Despite criticism and questionable claims the church prospered and its accounts of miraculous healing burgeoned. When Mark Twain wrote his famous essay "Christian Science" in 1903 the organization had grown to 263 churches throughout the country. At a meeting of the Hospital's Clinical Society on April 19, 1904, Dr. Pierson presented a paper on Christian Science followed by a discussion among members "who furnished some amusing as well as interesting instances of the fallacies of the cult."

The Christian Science Church, of course, was founded by a woman and a majority of its early followers and beneficiaries were women.[7] The year 1875 saw three significant developments in women's health care in the United States: Mrs. Eddy published her first edition of "Science and Health"; Dr. Mitchell published his first essay on the rest cure; and Lydia E. Pinkham made the first sale of her vegetable compound, selling six bottles for $5.00 to neighbors in Salem. Dr. Mitchell's essay "Rest in the Treatment of Nervous Disease," was directed essentially at the nervous woman whom he portrayed as fragile, vulnerable, and less fitted than man to face the stresses of daily life. The respective writings of Eddy and Mitchell went through many editions. Eddy, Mitchell, and Pinkham prospered mightily in the ensuing decades as medical saviors of those afflicted with "female trouble."

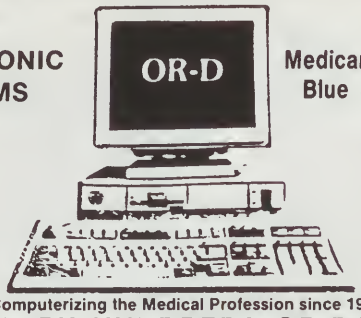
It is one of the ironies of history that Christian Science may have offered the support and healing to its female following that a misogynous medical tradition lacked. Christian Science offered painless rest and comfort to neuroasthenic or hysterical patients who might otherwise have been exposed to damaging medical or surgical treatments. ■

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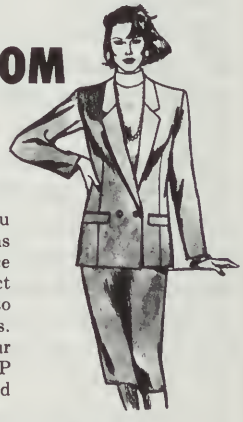
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Oral-Activated Charcoal

An Old Friend Revisited

ARIF S. ALAM, MD
ALAN CABASSO, MD

Emergency management of an accidental or intentional overdose involves rapid evaluation of patient status, supportive measures, and prevention of further absorption of the intoxicant.[1-7] Removal of the ingested toxins and drugs from the gastrointestinal tract form the cornerstone of toxicologic therapy. The severity and risk of complications of the intoxication are related to the amount absorbed, and the length of time the absorbed poison remains in the body. The management of such cases traditionally has been accomplished by induced emesis, gastric lavage, catharsis, or oral-activated charcoal (OAC).[8] Increasingly, it is being recognized that OAC, either alone or in combination with a cathartic, is at least as effective in preventing absorption of certain drugs as is gastric emptying.[7,9-11,24] This is important since syrup of ipecac has limitations and side effects.[12-20]

CHEMISTRY

Activated charcoal (AC) is a light, finely divided, black powder. It is prepared by pyrolysis of carbonaceous material, such as wood, coconut shells, or petroleum, and oxidized using steam or air at high temperatures (600° to 900° C). This process results in small particles of charcoal with an extensive internal network of pores. The size and number of pores that develop determine the surface area of the AC and its adsorptive capacity. The adsorptive capacity of AC is primarily dependent on the manufacturing process. The duration of the oxidation process and the temperature at which oxidation occurs determines the surface area of the charcoal. The surface area of the standard AC available for clinical use in the United States is 950 square meters/gram (sq m/g). Recently, a new form of charcoal, super-activated charcoal, has become available. It has a surface area of 2,500 to 3,500 sq m/g.[21,24]

Drs. Alam and Cabasso are affiliated with Jersey Shore Medical Center. The paper was submitted in July 1990 and accepted in October 1990. Requests for reprints may be addressed to Dr. Cabasso, Jersey Shore Medical Center, 1945 Corlies Avenue, Neptune, NJ 07754.

MECHANISM OF ACTION

AC is thought to work via two mechanisms: prevention of poison absorption, and increased poison clearance.[24]

AC binds most drugs and poisons from the gastrointestinal tract.[21] The effectiveness of charcoal depends on the dose and type of charcoal administered, the time of AC ingestion following ingestion of the poison, and the presence of competing substances. Typically, the maximum amounts of substances absorbed to charcoal in vitro range from 500 to 1,000 mg/g of standard activated charcoal. Super-activated charcoal can absorb two to three times the amount of drug or poison.[25]

Animal studies have suggested an optimal charcoal-to-poison ratio of 10:1.[26] Human studies suggest higher doses may be required for maximal effect.[27] The effectiveness of AC is best when it is ingested within one hour of toxin ingestion.[28-30] A number of considerations, however, dictate against the setting of any time limits: time of ingestion frequently is unknown; certain drugs have slower absorption; increased use of sustained-release medications; and some drugs may decrease gastrointestinal motility.[24]

Most drugs can re-enter the intestinal tract from the vascular compartment by diffusion, active secretion, or enterohepatic recycling in bile.[31] In addition, many drugs can be concentrated in gastrointestinal fluids by ion trapping.[32] Subsequently, the presence of a large, unbound amount of charcoal creates a drug concentration gradient between the blood and intestinal contents. This concentration gradient allows diffusion of the drug from

the circulation into the intestinal lumen to be bound to the charcoal.

This knowledge of these two mechanisms has led to the concept of treatment with multiple dose-activated charcoal (MDAC). MDAC, or pulse charcoal therapy, involves the administration of a loading dose of charcoal followed by maintenance doses every two to six hours. The concomitant use of a cathartic will prevent constipation and subsequent desorption of the drug from the charcoal. This especially may occur in cases that involve ingestion of medications that decreases gastrointestinal motility, e.g. narcotics, tricyclics, anticholinergics. Increased clearance of drugs, toxins, poisons, and other substances has been termed "gastrointestinal dialysis" by Levy.[33] He further has postulated that gastrointestinal dialysis is comparable to peritoneal dialysis. A brief list of compounds that demonstrate increased clearance with MDAC therapy includes benzodiazepines, carbamazepine, dapsone, digitoxin, digoxin, methotrexate, nadolol, phenobarbital, phenylbutazone, phenytoin, quinine, salicylates, theophylline, and tricyclic antidepressants.[24,30-31,40]

EFFICACY AND SAFETY

Since AC binds most drugs and chemicals, it would be far easier to list those for which the use of charcoal is not recommended: caustics (mineral acids, inorganic alkali), cyanide, electrolytes, ethanol, ethylene glycol, hydrocarbons, iron, and methanol.[24,34-35] Tolbutamide, lithium,[36] boric acid,[37] and pesticides such as malathion, DDT, and N-methylcarbonate were formerly thought to be poorly adsorbed, but charcoal use now is recommended.[35,36] Recently, the successful use of super-activated charcoal in detoxifying laboratory rats poisoned with a lethal dose of potassium cyanide has been reported.[39] Factors that decrease the effectiveness of OAC include the presence of food in the stomach, as it may saturate the binding sites. Therefore, the dose of charcoal may need to be increased.

The use of OAC therapy for treatment of an acetaminophen overdose remains controversial. Spyker recommends OAC if less than four hours have elapsed since the ingestion, and then following it with N-acetylcysteine (NAC).[53] Several studies note, however, that use of OAC causes a decrease in NAC levels.[54-55]

ROLE OF CATHARTICS

The adsorption of a toxin to charcoal is a reversible process. Therefore, a prolonged gastrointestinal transit time may cause the equilibrium of the charcoal-toxin complex to shift towards desorption. The unbound toxin then would be able to exert its pharmacologic effect. Consequently, the use of a cathartic with OAC therapy has been recommended. Its purpose is twofold: to decrease gastrointestinal absorption of the toxin and to increase the excretion of the charcoal-toxin complex. Sorbitol seems best suited for this purpose.[41]

OAC is nonreactive and is not absorbed systemically. Oral administration results in occasional constipation. The combined use of OAC and cathartic is recommended.[24] Age and weight are not considered limitations to the safe use of MDAC following an oral or intravenous overdose.[47]

ADVERSE COMPLICATIONS

A few adverse complications are reported, including aspiration,[42] severe hypernatremic dehydration (associated with sorbitol-OAC),[43] intestinal obstruction,[44] charcoal bezoar formation,[45] and hypermagnesemia.[46]

DOSAGE AND COMPLIANCE

The commonly recommended dose of AC for children is 15 to 30 g initially, followed by 15 g every three to four hours if MDAC is indicated. Alternatively, 1 to 2 g/kg may be used. The adult dose is 30 to 100 g initially, followed by 30 g every three to four hours if MDAC is indicated.[38] A dosage of 0.25 to 0.5 g/kg/h has been recommended for continuous infusion.[48]

Commercial OAC-sorbitol preparations maintain a concentration of 70 percent sorbitol. In children, the dose is 1 g/kg sorbitol,[49] although its use in young children needs to be studied further.

Three interrelated problems with charcoal therapy are palatability, compliance, and mess. Charcoal and water slurries are gritty and stick to the oral mucosa.[50] Cooney showed that the addition of sucrose (1:1), saccharin (1:20), or sorbitol (1:1) enhanced the palatability of the slurry, and each preparation was accepted readily by the study participants.[51] Calvert reported 86 percent of children offered AC accepted it.[52] ■

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Terbutaline-Induced Pulmonary Edema

AMIR AZARNIVAR, MD
JAY A. ERLEBACHER, MD
WILLIAM SOULE, MD

Beta$_2$-agonists such as terbutaline, ritodrine, and fenoterol are widely used in obstetrics to arrest premature labor due to their relaxant tocolytic effects on the pregnant uterine myometrium. Despite their relative selectivity, beta$_2$-agonists, nonetheless, can produce significant adverse circulatory, renal, and metabolic effects. The beta$_2$-agonists have well-described cardiopulmonary toxicity including acute pulmonary edema,[1] angina,[2] cardiac arrhythmias,[2,3] and symptomatic hypotension.[4,5] Acute pulmonary edema has been reported in approximately 5 percent of women with preterm labor treated with beta$_2$-agonists.[6] We report a case of terbutaline-induced pulmonary edema in a woman with premature labor treated at Englewood Hospital.

CASE REPORT

A 40-year-old black primigravida presented in her 20th week of pregnancy with premature labor. The patient was known to have multiple uterine myomata, and this was thought to be a precipitating cause. She was treated initially with intravenous magnesium sulfate at 2 gm/hr without improvement. Terbutaline was added on day two: 0.25 mg subcutaneously every 30 minutes for five doses and then 5 mg orally every 2 hours for 24 hours. This regimen was repeated on day three. Morphine sulfate was administered, 15 mg subcutaneously every 4 hours for 24 hours for relief of pain thought to be due to benign degeneration of uterine myomata. Terbutaline was continued on days four and five: 5 mg orally every 2 hours. D5 1/2 NS was infused at a rate of 2 L/24 hr.

On day five, our patient complained of increasing dyspnea and palpitations. Physical examination revealed a regular pulse of 110 beats/min and a blood pressure of 120/80. Jugular venous pressure was 5 to 8 cm H_2O. Rare wheezes were heard but there were no rales. A grade II/VI early systolic murmur was heard at the left sternal border but there was no audible S3 or S4 gallop. Trace pitting pedal edema was present. A chest x-ray showed bilateral infiltrates in a butterfly distribution consistent with pulmonary edema.

The patient was empirically given furosemide 20 mg intravenously and diuresed 300 cc before a Swan-Ganz catheter was inserted. Right heart pressures were: right atrium 12 mm Hg, pulmonary artery 48/20 mm Hg, and pulmonary capillary wedge 21 mm. These readings were felt to be consistent with either volume overload or cardiac dysfunction as the possible causes of pulmonary edema. However, a bedside two-dimensional echocardiographic examination demonstrated normal valvular and ventricular function, leaving volume overload as the diagnosis of exclusion.

The patient was treated with furosemide, reduction in intravenous fluid administration rate, and withdrawal of terbutaline. Symptoms and signs of congestive heart failure rapidly resolved.

Dr. Azarnivar is a resident in internal medicine, and Dr. Erlebacher is an attending in cardiology, and Dr. Soule is an attending in obstetrics, Englewood Hospital. The paper was submitted in July 1990 and accepted in October 1990. Requests for reprints may be addressed to Dr. Azarnivar, Englewood Hospital, 350 Engle Street, Englewood, NJ 07631.

DISCUSSION

The pathophysiology of pulmonary edema associated with the use of beta$_2$-agonists is not clearly established. Certain factors predisposing to pulmonary edema in this setting include anemia, twin gestation, corticosteroid use, and pre-existing cardiac disease.[7] Several mechanisms by which beta$_2$-agonists cause pulmonary edema have been proposed; these can be broadly divided into noncardiogenic and cardiogenic mechanisms.

Proposed noncardiogenic mechanisms include: fluid overload and increased pulmonary capillary permeability, e.g. drug-induced noncardiogenic pulmonary edema. Fluid overload may be caused by intravenous hydration plus renal effects that are directly and indirectly casued by beta$_2$ stimulation. In studies performed in pregnant sheep, beta$_2$-agonists caused an increase in arginine vasopressin plasma level with an attendant antidiuretic effect.[8] Furthermore, there is an increase in tubular sodium reabsorption due to beta stimulation of the renin-angiotensin system and/or a direct effect on the renal tubules. In addition, renal plasma flow, glomerular filtration rate, and urine output fall significantly during beta$_2$-agonist infusion.[8] All these factors contribute to a progressively positive fluid balance and fluid overload. This type of fluid overload appeared to be the cause of pulmonary edema in our patient inasmuch as the pulmonary capillary wedge pressure was elevated, even after a significant diuresis.

It also has been proposed that beta$_2$-agonist-induced noncardiogenic pulmonary edema is due to increased pulmonary capillary permeability. This hypothesis is based primarily on case reports of pulmonary edema associated with beta$_2$-agonists where invasive monitoring revealed normal pulmonary capillary wedge pressures with elevated cardiac output.[9,10] Also, animal studies of beta$_2$-agonist-induced hemodynamic changes have failed to induce pulmonary edema, implying that an additional factor such as increased pulmonary capillary permeability may be necessary for the syndrome to manifest. However, direct evidence of increased capillary permeability is lacking in experimental and clinical studies, and, therefore, this mechanism remains speculative.

A cardiogenic etiology of beta-agonist-induced pulmonary edema has been proposed on the basis that high levels of beta stimulation can produce subendocardial myocardial ischemia and left ventricular dysfunction. However, echocardiographic evaluations of patients with beta$_2$-agonist-induced pulmonary edema, including the case presented here, show normal to supernormal left ventricular function, making a cardiogenic etiology unlikely.[11]

Most patients recover promptly when the diagnosis of beta-agonist-induced pulmonary edema is quickly recognized and treated. Measurement of daily weight and careful monitoring of fluid intake and output is necessary during beta$_2$-agonist therapy. Key to the diagnosis is a high index of suspicion and early evaluation of the chest x-ray. In our case, auscultation did not reveal signs of the patient's heart failure. Pulmonary edema can develop rapidly, even with modest hydration.

Cessation of beta$_2$-agonist therapy, oxygen, and diuretics suffice as ordinary treatment.[9] Beta$_1$-specific blockers such as metoprolol and atenolol have been recommended to antagonize the cardiac effects while permitting continued tocolytic effects of the beta$_2$-agonists.[12] Better awareness of beta$_2$-agonist-induced pulmonary edema as a cause of unexplained dyspnea in women being treated with tocolytic agents will remain the most important diagnostic tool in its diagnosis and treatment. ■

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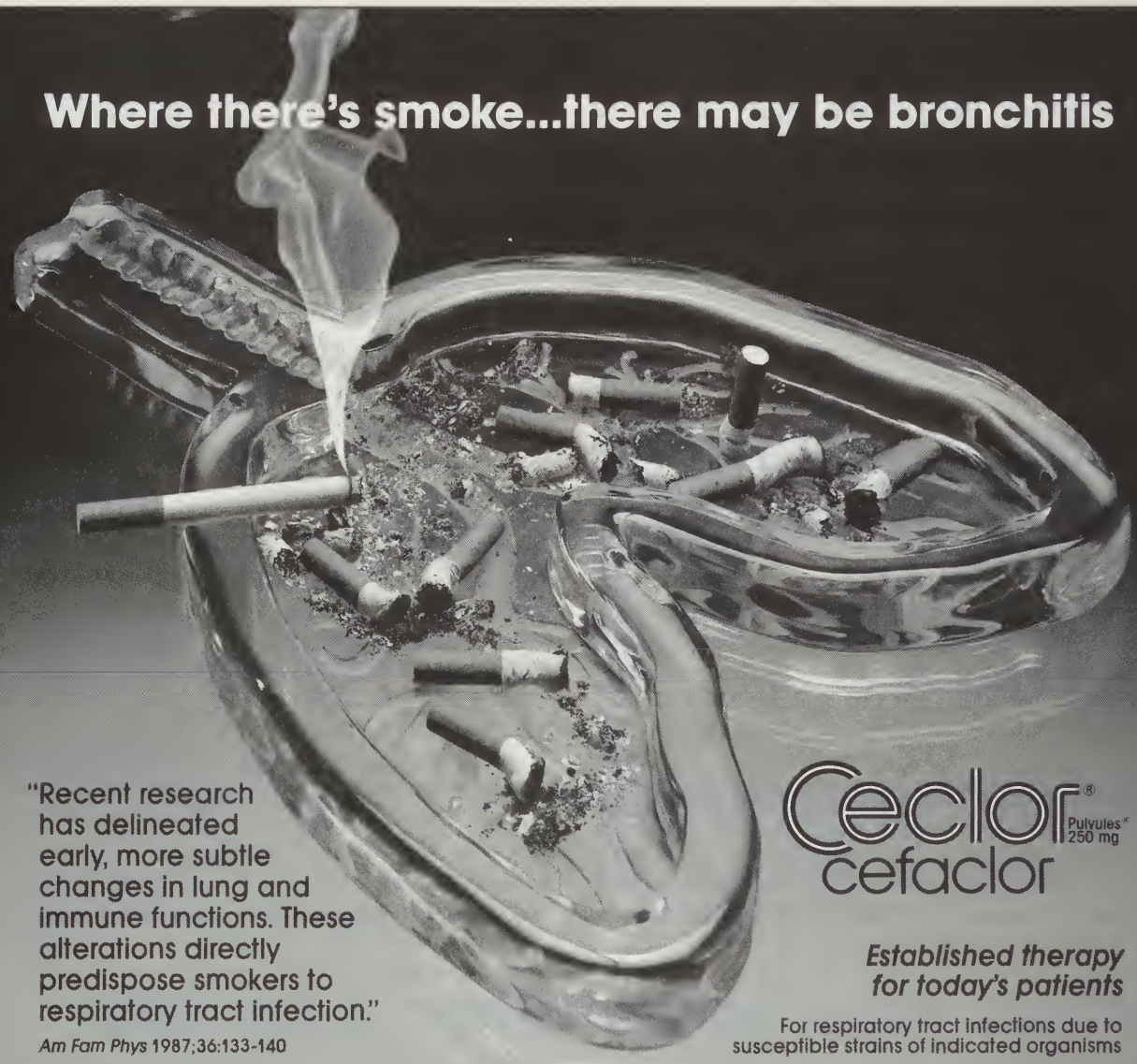
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• Discontinue Ceclor in the event of allergic reactions to it.
• Prolonged use may result in overgrowth of non-susceptible organisms.
• Positive direct Coombs' tests have been reported during treatment with cephalosporins.
• Ceclor should be administered with caution in the presence of markedly impaired renal function. Although dosage adjustments in moderate to severe renal impairment are usually not required, careful clinical observation and laboratory studies should be made.
• Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.
• Safety and effectiveness have not been determined in pregnancy, lactation, and infants less than one month old. Ceclor penetrates mother's milk. Exercise caution in prescribing for these patients.

Adverse Reactions: (percentage of patients)

Therapy-related adverse reactions are uncommon. Those reported include:
• Hypersensitivity reactions have been reported in about 1.5% of patients and include morbilliform eruptions (1 in 100). Pruritus, urticaria, and positive Coombs' tests each occur in less than 1 in 200 patients. Cases of **serum-sickness-like** reactions have been reported with the use of Ceclor. These are characterized by findings of erythema multiforme, rashes, and other skin manifestations accompanied by arthritis/arthralgia, with or without fever, and differ from classic serum sickness in that there is infrequently associated lymphadenopathy and proteinuria, no circulating immune complexes, and no evidence to date of sequelae of the reaction. While further investigation is ongoing, **serum-sickness-like** reactions appear to be due to hypersensitivity and more often occur during or following a second (or subsequent) course of therapy with Ceclor. Such reactions have been reported more frequently in children than in adults with an overall occurrence ranging from 1 in 200 (0.5%) in one focused trial to 2 in 8,346 (0.024%) in overall clinical trials (with an incidence in children in clinical trials of 0.055%) to 1 in 38,000 (0.003%) in spontaneous event reports. Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy; occasionally these reactions have resulted in hospitalization, usually of short duration (median hospitalization = two to three days, based on postmarketing surveillance studies). In those requiring hospitalization, the symptoms have ranged from mild to severe at the time of admission with more of the severe reactions occurring in children. Antihistamines and glucocorticoids appear to enhance resolution of the signs and symptoms. No serious sequelae have been reported.
• Stevens-Johnson syndrome, toxic epidermal necrolysis, and anaphylaxis have been reported rarely. Anaphylaxis may be more common in patients with a history of penicillin allergy.
• Gastrointestinal (mostly diarrhea): 2.5%
• Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment.
• As with some penicillins and some other cephalosporins, transient hepatitis and cholestatic jaundice have been reported rarely.
• Rarely, reversible hyperactivity, nervousness, insomnia, confusion, hypertonia, dizziness, and somnolence have been reported.
• Other: eosinophilia, 2%; genital pruritus or vaginitis, less than 1% and, rarely, thrombocytopenia and reversible interstitial nephritis.

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HMOs: Survival of the Fittest

JUDITH M. CONSIDINE, PhD
LESLIE S. OAKES, PhD

The health care environment has changed dramatically from 1950, when the cost of health care was 4.4 percent of the gross national product (GNP), to the 1990s as health care costs climb to over 11 percent of the GNP.[1] The increases in costs are due to changes in the practice of medicine and demographics, increased demands for access to services, and the introduction of high-technology diagnostic tools and treatments. In New Jersey, these changes are occurring at a very rapid rate. For New Jersey physicians, the ability to provide optimal health care may depend on understanding more than the practice of medicine. More than ever, survival may depend on understanding how the economic environment impacts providers, patients, and third-party payers.

Partners in Health Care. There are four parties involved in health care services: the patient, the provider, often a physician, the hospital or institutional entity that provides care, and the third-party payer. Financial pressure has mounted on each of these four parties in the past decade.

The patient population has changed. Demographics demonstrate that the over-65 age group is growing twice as fast as the general population. With the baby boomers approaching middle age, their need for health care resources will increase. In addition, pressure exerted by special interest groups will be felt to a greater extent. In the future, senior citizens and patients with specific diseases will continue to lobby for greater access and for control of their health care costs. Physicians and other providers can expect federal involvement on behalf of Medicare and Medicaid patients and uninsured patients to expand as the cost of health insurance continues to rise.

Physicians and hospitals face accelerating competition, rising fixed and variable costs, and increased demands by patients and by third-party payers. Extra paperwork, regulations of governmental agencies, and the ever-changing economic climate create problems for all providers. Increasingly, medical practice is viewed as a business and not merely as an individual professional enterprise.

Third-party payers also are in a continual state of transition. High costs have splashed red ink on even the most stable of insurers, Blue Cross/Blue Shield. In 1987, the Blues lost two billion dollars nationwide. The 1980s saw the dramatic growth of health maintenance organizations (HMOs). This type of managed care was expected to decrease the cost of health insurance. However, many employers who offer HMO coverage to their employees have seen their overall health insurance costs rise. Often, the traditional indemnity plan continues to be the choice of poor-risk patients while HMOs attract younger, healthier employees.[2] Prior to the recent revisions in the HMO Act of 1973, employers were required to make the same contribution toward the premium charged by the HMO as they did to the non-HMO plans. If the premium for coverage by an HMO was equal to or less than that for the indemnity plan, no cost savings resulted for the employer.[2] The recent revisions allowed employers to develop group specific rates by age or by sex and to charge the employee for part of the health care costs.

The Changing Nature of Third-Party Payers. In New Jersey, HMOs now enroll approximately one of every eight individuals covered by insurance.[3] There are 20 HMOs operating within the state, and of these, only 1 HMO is unaffiliated with a major insurance company and would be considered domestic, a term used to describe a firm operating within a single locale. This number of domestic

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HMOs decreased in recent months with the merger of several HMOs into larger firms.

In New Jersey, the shift away from local HMOs toward horizontally integrated networks reflects a national trend that began in the late 1970s. In 1970, InterStudy, a Minnesota-based research group that has gathered data on HMOs for two decades, identified 37 HMOs in 14 states. By 1975, 183 HMOs were in operation with an enrollment of 6 million individuals. By June 1985, nearly 20 million individuals were insured by HMOs and by early 1989 the total enrollment reached nearly 33 million individuals.[4] The once rapid growth in both enrollment and the number of new plans now is being replaced by controlled growth, with a greater focus on the efficiency and effectiveness of plan operations.

In addition to the shift to national HMO chains, there has been a growth in new hybrid models and preferred provider organizations (PPOs). These models combine the most attractive features of managed care and indemnity insurance giving the patient more choice in the selection of providers along with an assumption of greater financial risk. The multiplicity of these programs has created confusion for both the physician and the consumer.

From the insurer's perspective, hybrid plans are easier to market because often they are open-ended. They give some flexibility to the patient and allow the patient to select a physician. When the patient selects a provider not affiliated with the HMO, the plan places an increased financial burden on patients in the form of increased copayments and deductibles. Currently, 11.5 percent of HMOs offer these flexible open-ended plans.[5]

PPOs are similar to HMOs in structure. A PPO markets to specific employers and presents a package of health care services at a cost hoped to be lower than the charges of the individual providers in the area. In New Jersey, the state introduced a PPO as a health care option for its employees. An ab-

Table 1. ***Comparison of the benefits of various state insurance plans.****

Benefit	PPO		Indemnity	HMO
	In-Network	Out of Network		
Hospital				
Inpatient	Covered in full	$200 deductible per stay	120 days full coverage	Covered in full
Outpatient	$25 copay then full coverage	Covered under major medical	Full coverage	Covered in full
Physician				
Office visits	$5 copay	$100 annual deductible/then major medical	Covered under major medical	$3-$10 copays
Immunizations	Covered in full	Not covered	Not covered	Covered in full
Preventive	Covered in full	Not covered	Not covered	Covered in full
Miscellaneous				
Physical therapy	Major medical coinsurance—90/10	$100 annual deductible, coinsurance 70/30	Covered under major medical	Copay varies
X-ray and Lab	Covered in full	$100 annual deductible coinsurance 70/30	Covered under major medical	Covered in full
Maximum Out-of-pocket Expenses				
Individual	$ 400	$2000	$ 500	Varies
Family	$1000	$5000	$1000	Depends on copay for various programs
Coinsurance rate	90/10	70/30	80/20	None

*The New Jersey State Health Benefits Program Information Handbook, 1989

breviated example of the variations in the types of plans offered by the state is presented in Table 1.[6]

Small HMOs are being replaced by insurer-initiated, vertically integrated HMOs in New Jersey and across the nation. The largest insurance companies are devising and distributing integrated prepaid and indemnity products through their own channels. For example, CIGNA has 19 HMOs; 1 HMO that was started in New Jersey recently was the Healthcare Connection in association with Allied Signal Corporation. This placed 67,000 employees in a national open-ended HMO.[7] Prudential has 17 HMOs and in New Jersey has offered a PPO to New Jersey state employees (Table 1). Metropolitan Life Insurance Company offered its Metlife Network as an available option in various parts of the state. Across the country, some of the large HMOs have entered the hybrid plan market; for example, U.S. Healthcare is participating in a joint venture with Lincoln National. All of this adds up to rapid change as the industry is aggressively pursuing managed care products.

This response by large insurance firms, known as the "Supermeds," probably is best viewed from a financial perspective. The typical profit margins on indemnity-type medical insurance run from 1 to 3 percent; however, much larger HMO profit margins are expected.[8] For this reason and because of a desire to increase market share, many group insurers are moving into the managed care area. The managed care market is consolidating because of the oversupply of HMOs in certain markets resulting in intense competition, the ever-increasing overhead costs in the areas of marketing and systems analysis and the trend toward integrated products. Many people believe that the "Supermeds" will prevail because of their ability to drive the development of new products on behalf of their corporate employer customers.

An Emphasis on Cost. In New Jersey, as in other states, HMOs control costs primarily through the "gatekeeper," the primary care physician. In the classic indemnity coverage, there is no single provider responsible for control of either cost or utilization of services. HMOs attempt to control the utilization of services and, thus, the cost of health care by a number of methods, including: all hospitalizations, except emergencies, must be preauthorized; referrals to specialists must be authorized by the primary care physician; and laboratory testing and many other diagnostic procedures are to be performed by designated participating providers. A growing number of plans place limitations on specific types of coverage such as mental health and substance abuse programs.

HMOs frequently provide certain financial incentives to physicians, including bonuses, in an effort to control costs if the use of hospital and emergency services is lower than anticipated. These incentives place the financial risk squarely on the physician and may represent a disabling conflict of interest. (The physician does not select the patient panel but must endeavor to provide excellent medical care.) In the individual practice association (IPA) model the return of the withhold amount, originally kept to be used as a risk pool, is a method to encourage cost efficiency. These "financial incentives" have led to lawsuits for some of the national HMO groups,[9] and a call in Massachusetts for greater disclosure of financial incentives.[10]

In an attempt to remedy conflicts created by incentives, US Healthcare has moved to a model that

Table 2. ***Results of the National Survey of Insurance Regulators.***

Consideration	National Responses	New Jersey Response
Percent of market penetration within each state?	10.3%	11.3%
Have the number of HMOs increased or decreased?	Increased = 13% Decreased = 50% No change = 13% No answer = 14%	Decreased
Does your state have a reserve requirement?	Yes = 87.5% No = 12.5%	No reserve requirement
Does your state have a financial reporting requirement?	Yes, quarterly and annually = 60% Yes, annually = 15% Yes, quarterly, annually and sometimes monthly = 15% No = 10%	Quarterly and annually

attempts to integrate quality measures with the payment system.[11] The quality aspect is based on four measures: satisfaction of each office's HMO patients, chart audits, transfer rates, and evaluation of each office's ability to participate effectively in the corporate structure.

Financial Problems of Third-Party Payers. In recent years, New Jersey physicians and other providers have found they must worry about the financial problems of their own practice and about the fiscal status of HMOs. As HMOs lose money, some are filing for Chapter 11 protection as a means of delaying or preventing bankruptcy. Contracting providers are left with unpaid bills and the promise of greater liabilities in the future. For example, primary care physicians may not legally be able to terminate their present contract merely because an HMO files for bankruptcy or is late in paying a claim. In fact, the contract may provide for continued care to the HMO enrollees and even acceptance of new patients for the period of time specified. Most HMO contracts have "hold harmless" clauses, that protect the patients from being billed directly for services and assures them continuing treatment while the State Department of Insurance moves on reorganization. As in any other Chapter 11 bankruptcy filing and subsequent reorganization, the amount any creditor can collect is subject to a court-approved plan.

Questions about accounting methods have been spurred by recent losses by 70 percent of the nation's 600 plus HMOs. Maxicare's tailspin into bankruptcy is the most publicized of these reversals. Concerns regarding the solvency of HMOs have caused many states to exercise more control.[12] Most states now routinely require HMOs to file financial statements with either the Department of Insurance or the Department of Health. However, the financial statements also may present problems. For example, Kenkel states one problem is the difficult estimation of incurred but not reported claims, suggesting that "it is an educated guess, at best."[13] This problem may lead to inaccurate rate setting because the cost data are incomplete and/or incorrect. Another problem is the lack of accounting and actuarial expertise at some HMO firms. More states are considering guaranty funds and net worth requirements for HMOs, similar to those recently instituted for savings and loan associations.

NAHMOR. The National Association of Health Maintenance Organization Regulators (NAHMOR) has established a set of financial indicators to assist state regulators in determining the solvency of HMOs. These are the first set of indicators that attempt to predict the financial status of the HMOs. The objective of state regulators is the preservation of the health benefits that the HMO has contracted to provide to the subscriber. Thus, even if the state has a guaranty fund, the monies are more likely to be spent to cover the financial risk of the patient. The providers, both physicians and hospitals, assume the greatest risk. Table 2 presents some results of a nationwide survey of insurance regulators.[14] It compares New Jersey's requirement with 39 other states whose regulators responded to the survey. Note that the Department of Insurance does not require a reserve fund in New Jersey, while 87.5 percent of the other states respondents have this requirement, although in amounts ranging from $10,000 to millions of dollars.

In the current United States health care system, the financial health of the insurance industry is a necessary and important link. Providers and patients alike will feel the effect of poor monetary and bad business practices of these new health insurance entities. Changes due to poor HMO positioning in a competitive marketplace may result in inadequate fees while increasing the demand for medical services. Ineffective utilization controls and inadequate capitalization may strangle HMO financial stability. The result may be additional new governmental controls aimed at guaranteeing both the providers and the patients fair protection. In short, consumers must be protected. ■

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Obstruction of the Inferior Vena Cava

JAMES H. JACOBY, MD
DANIEL D'AURIA, MD

A 43-year-old Hispanic male presented with the insidious onset of lower extremity edema, right-sided chest tightness, and increasing abdominal girth. He denied fever, chills, or abdominal pain. Physical examination revealed the abdomen to be distended with bulging flanks. There was prominent venous pattern over the epigastrium and lower anterior chest. Prominent thoracoepigastric veins were seen extending over the lateral abdomen and chest bilaterally; these appeared to fill caudally. Shifting dullness was present. The liver was firm and palpable 8 cm below the right costal margin in the right midclavicular line. The spleen was firm and palpable 7 cm below the left costal margin. There was bilateral pitting edema of the lower extremities and clubbing of both the fingers and toes. Chest x-rays revealed a large right pleural effusion. An ultrasound evaluation of the abdomen was performed.

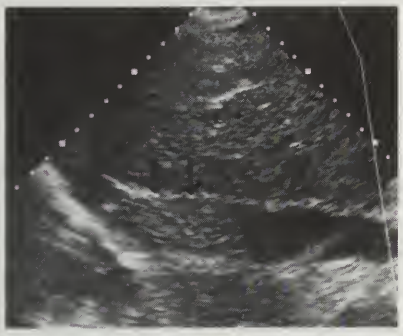


Figure 1. Right sagittal sonogram through the liver and inferior vena cava. Note echogenic areas (arrows) within the inferior vena cava.

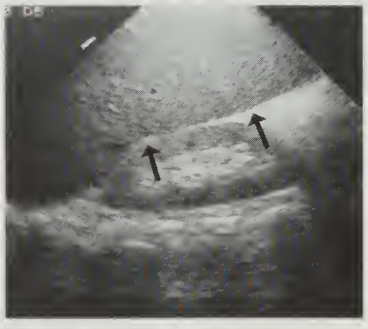


Figure 2. Left sagittal sonogram through spleen (arrows) and left kidney showing considerable splenomegaly.

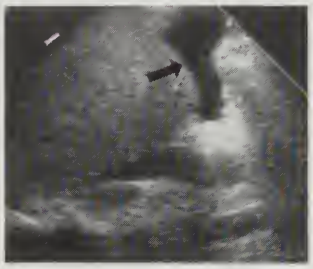


Figure 3. Right sagittal sonogram through inferior edge of right lobe of the liver. Note echo-free area (arrow) below inferior edge of liver, indicative of ascites.

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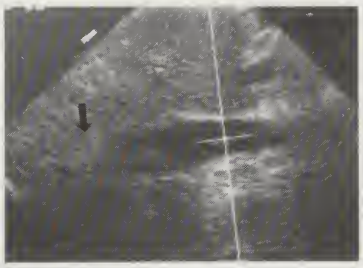


Figure 4A. Right sagittal sonogram through inferior vena cava with doppler cursor placed just distal to the level of thrombus (arrow).

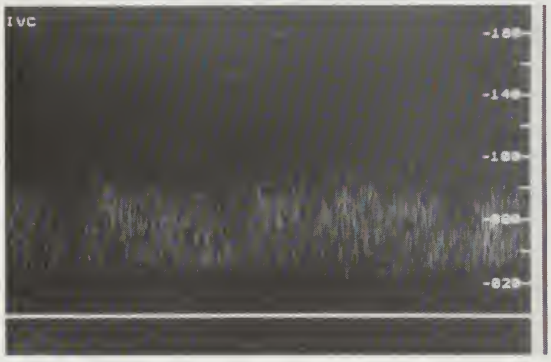


Figure 4B. Normal doppler signal obtained through inferior vena cava distal to the level of the thrombus.



Figure 4C. No significant doppler signal obtained through region of thrombus in the proximal inferior vena cava.

DISCUSSION

The ultrasound studies demonstrated considerable echogenic material representing thrombus in the inferior vena cava just below the level of the diaphragm (Figure 1), extensive splenomegaly (Figure 2), and evidence of ascites (Figure 3). This constellation of findings represents a rare disorder that typically presents as a triad of abdominal pain, ascites, and hepatomegaly, commonly known as Budd-Chiari syndrome. Distribution of the venous obstruction includes: occlusion of the inferior vena cava with or without occlusion of the hepatic veins; occlusion of the hepatic veins with or without inferior vena cava occlusion; and occlusion of the small centrilobular veins. Although this usually is idiopathic, it also has been associated with hypercoagulable states, e.g. polycythemia vera, oral contraceptives, neoplasms (hepatic, renal, adrenal, and inferior vena caval), chronic leukemia, trauma, pregnancy, and hepatic webs. None of these conditions was present in this patient.

Traditionally, hepatic venography and venacavography have been the standards used for establishing the diagnosis. Ultrasound is very well suited, however, for demonstrating the findings of hepatomegaly, ascites, and splenomegaly. In addition, thrombus often can be directly visualized in the hepatic veins and/or the inferior vena cava. Additionally, doppler interrogation of the inferior vena cava can demonstrate normal flow just distal to the level of the obstruction with no doppler signal being obtained through the area of thrombus (Figures 4A, 4B, and 4C).

Computed tomography (CT) appearance is similar to ultrasound and often is highly suggestive. In the acute phase, hepatomegaly and ascites, although nonspecific, are hallmarks of Budd-Chiari syndrome and the hepatic veins are not well demonstrated. Dynamic bolus enhancement imaging is useful and reveals early fan-shaped patchy increased areas centrally near the inferior vena cava that later revert to decreased attenuation with general hepatic inhomogeneity. "Comma-shaped" areas of diminished attenuation also can be seen. Because of separate venous outflow from the caudate lobe, the caudate lobe may remain large as the remainder of the liver atrophies in chronic obstruction.

Magnetic resonance imaging (MRI) can reveal equal changes of reduced caliber or obstructed hepatic veins with the presence of "comma-shaped" signal voids representing collateral vessels. MRI is particularly well suited for patients demonstrating clot and poor flow in the hepatic veins and inferior vena cava.

This patient was treated with anticoagulants and diuretics. His edema resolved and the ascites improved.

Diagnosis: Budd-Chiari syndrome. ■

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Prescribing Under OBRA

Myth and Reality

KENNETH J. WEISS, MD

The Omnibus Budget Reconciliation Act (OBRA) aims to reduce unnecessary psychotropic drugs in nursing facilities, bringing prescribing practices under scrutiny. Yet, OBRA can be adapted by physicians.

Increasing numbers of persons with dementia, developmental disabilities, and stabilized chronic mental illness are being admitted to nursing facilities. Greater attention has been paid to these citizens and the treatment prescribed for them. Questions have arisen as to whether many patients are overmedicated or excessively restrained. Congress has responded to this concern by passing the Omnibus Budget Reconciliation Act (OBRA) in 1987.[1] After substantial effort in translating the law into regulations, the Health Care Financing Administration (HCFA) has set forth requirements for the prescribing of psychotropic medications for patients in long-term nursing facilities participating in Medicare and Medicaid programs.[2] Attending physicians may need to adjust prescribing practices so that facilities can maintain compliance with OBRA regulations. The goal of this article is to highlight some of the practical aspects of OBRA for physicians and to address some of the myths that have developed about this new law.

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WHAT OBRA REQUIRES

The intent of OBRA is to enhance the quality of life for residents of nursing facilities who often cannot speak for themselves. The regulations endorse protection from unnecessary drugs and freedom from excessive restraint. The use of psychotropic medications will have to be closely monitored for appropriateness of indication and duration of use. The following is a partial list of prescribing practices that may be cited by Medicaid surveyors as out of compliance with OBRA:

1. *Unnecessary drugs.* Physicians will be monitored for prescribing unnecessary drugs, e.g. lack of indications, excessive dosage and duration, causing side effects, used for restraint, not monitored for serum levels. A diagnosis of dementia or Alzheimer's disease is not a sufficient indication for a psychotropic medication to control behavior. A

diagnosis of organic anxiety disorder or organic personality syndrome may indicate the rationale for medication use in patients with dementia.

2. *Antipsychotic drugs.* Patients already on antipsychotic drugs must receive gradual dosage reductions or behavioral programming, in an effort to discontinue the drug. Except for those patients with a specific condition, e.g. schizophrenia, mania, patients not previously on antipsychotic drugs must not receive them.

3. *As occasion requires (PRN) prescriptions.* Medications prescribed should not be used solely for the convenience of the facility, and alternatives to chemical restraints should be tried.

4. *Benzodiazepines.* The members of the benzodiazepine class of compounds with long elimination half-lives should not be prescribed for chronic use, since these drugs may increase the risk of hip fracture, e.g. diazepam (Valium®), chlordiazepoxide (Librium®), flurazepam (Dalmane®), clorazepate (Tranxene®), prazepam (Centrax®).[3] Short-acting compounds, e.g. lorazepam (Ativan®), temazepam (Restoril®), alprazolam (Xanax®), oxazepam (Serax®), also will come under scrutiny if prescribed chronically. The nonbenzodiazepine antianxiety drug, buspirone (BuSpar®), is not targeted by OBRA.

MYTHS ABOUT OBRA

OBRA regulates physicians' prescribing. There is no explicit control over what can be prescribed. However, annual site surveys under OBRA will be concerned with instances of unnecessary drugs and other problems within each facility. The surveyor may cite the facility for OBRA infractions, calling into question its eligibility for Medicare and Medicaid reimbursement. Hence, physicians' prescribing will impact upon the certification process.

OBRA outlaws drugs such as antipsychotics and benzodiazepines. The regulations are geared toward improving quality of life by reducing the amount of mind-altering drugs. However, the baby should not be thrown out with the bath water; that is, medications still should be used for valid indications. The key is justifying each prescription by documentation. For example, the antipsychotic drug haloperidol (Haldol®) is indicated for symptomatic control of hallucinations and paranoia, but would not be justified by a diagnosis of Alzheimer's disease alone or by documenting simple signs of dementia such as wandering or pacing.

OBRA forces physicians to practice "bad" medicine. Although the regulations appear to some to be heavy handed, they should not induce passivity among physicians. To the contrary, focusing on the new guidelines will encourage healthy discussion of the treatment of mental disorders among the elderly and chronically ill. It always has been good practice to consider differential indications for drugs and to use the least intrusive means available.

PRESCRIBING UNDER OBRA

The following are points to bear in mind when faced with OBRA regulations:

1. Physicians should become familiar with the indications for the various classes of psychotropic medications. Since compliance with OBRA is a team effort, advice from a psychiatrist and consulting pharmacist will be helpful.

2. Review all orders for psychotropic medications. Eliminate redundancies, discontinue drugs without demonstrable value, and consider dosage reduction for chronically prescribed drugs.

3. Do not consider antipsychotic drugs to be "all-purpose" agents. Carefully consider the indications for these drugs and document the target symptoms. Treat nonpsychotic anxiety and depression with appropriate medications. Keep up to date with developments of newer, safer, and more specific psychotropic drugs.

4. Be aware of psychotropic drug side effects. For patients on antipsychotic medication, OBRA requires regular monitoring for abnormal involuntary movements (tardive dyskinesia). Also, monitor elderly patients for the hypotensive effects of antipsychotic and tricyclic antidepressant drugs and for the sedating effects of benzodiazepines.

CONCLUSIONS

The OBRA regulations are likely to produce a decrease in the amount of medication received by nursing facility patients. If monitored carefully, this should not result in chaos in the facilities but improved quality of life for the patients. Although physicians may reasonably fear increased administrative time and effort, there also is an opportunity to assume a leadership position. ■

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One-Handed Wound Approximator

IAN D. SAMSON, MD

The author discusses a technique to bring skin edges together by a one-handed use of two Adson forceps.

Closure of skin wounds using a stapling device requires coaptation of the skin edges before firing the stapler. If forceps are used, an assistant is needed to approximate the wound edges or to provide a third hand to fire the stapler. Therefore, absence of an assistant precludes the use of a stapler by a surgeon working on his own. In New Jersey, where the Nursing Act disallows nurses handling instruments, this difficulty also is encountered.

Recently, Drs. Le and Ferrara described a technique to bring the skin edges together by the use of two pairs of Adson forceps held in one hand.[1] The technique is ingenious but difficult to learn. The author has devised an instrument to facilitate the simultaneous one-handed use of two Adson forceps (Pilling Company, 420 Delaware Drive, Fort Washington, Pennsylvania 19034). The device is simple and consists of a hinged bar connecting the Adson forceps. This mechanism provides a rigid, controllable instrument that allows for precise skin coaptation.

Editorial Comment: Somehow, from the deep recesses of the mind, we seem to remember an old French instrument with a central guiding strip and a fine lateral forceps that was employed to accomplish this same task by an old-time surgeon, working with minimal help.

Dr. Samson is affiliated with Community Memorial Hospital, Toms River, and Kimball Medical Center, Lakewood. This paper was submitted in November 1990 and accepted in December 1990. Requests for reprints may be addressed to Dr. Samson, Lakewood Surgical Group, PA, 5 Prospect Street, Lakewood, NJ 08701.

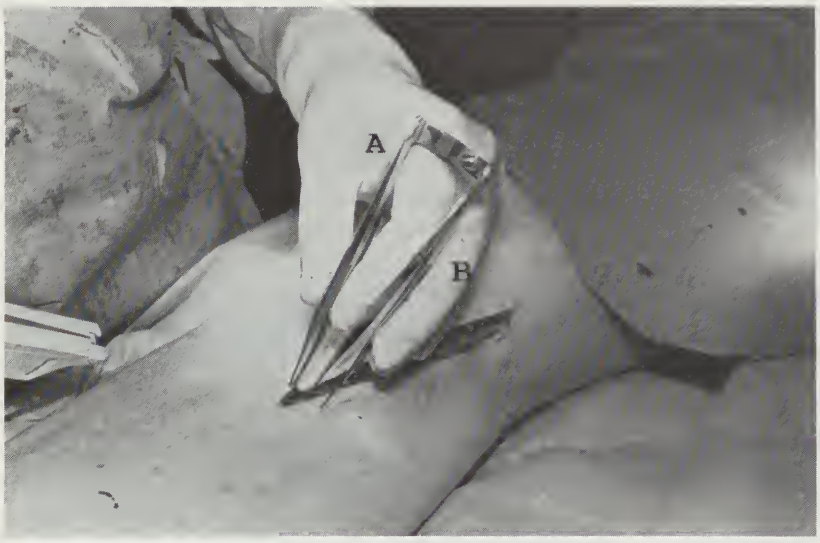


Figure 1. The instrument is held between the thumb, index, and middle fingers of the left hand. Forceps "A" is made to grasp the nearest edge of the skin, then is drawn over to approximate the farthest edge.



Figure 2. Forceps "B" is engaged, and the two edges brought into apposition. The stapler is fired and held in place until the Adson forceps are reapplied, when the staple is released.



Figure 3. Using the hinged Adson forcep, neat and accurate wound closure is easily achieved by a solo operator.

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1991 MSNJ ANNUAL MEETING

The Board of Trustees of the Medical Society of New Jersey approved the Committee on Annual Meeting's recommendation that the 1991 Annual Meeting be held at the Trump Taj Mahal Casino Resort in Atlantic City, on Sunday, April 28, through Wednesday, May 1, 1991. The Merv Griffin's Resorts Casino Hotel will participate with the headquarters hotel (Trump Taj Mahal) for the 1991 Annual Meeting. The daily schedule follows:

Saturday, April 27, 1991

3:30 p.m. Board of Trustees' Meeting

Sunday, April 28, 1991

8:00 a.m. Registration Opens
8:00 a.m. Message Center Opens
10:00 a.m. Educational Programs
11:30 a.m. Exhibits Open
1:30 p.m. House of Delegates
3:30 p.m. Reference Committee Meetings

Monday, April 29, 1991

8:00 a.m. Registration Opens
8:00 a.m. Message Center Opens
8:30 a.m. Exhibits Open
9:00 a.m. House of Delegates (Election)
12:00 noon Golden Merit Award Ceremony and Reception
2:30 p.m. Reference Committee Meetings
5:00 p.m. JEMPAC Political Forum
5:45 p.m. JEMPAC Wine and Cheese Reception
6:30 p.m. Union County Medical Society Reception

Tuesday, April 30, 1991

8:00 a.m. Registration Opens
8:00 a.m. Message Center Opens
8:30 a.m. Exhibits Open
9:00 a.m. House of Delegates
1:30 p.m. House of Delegates
7:00 p.m. Inaugural Reception and Dinner
honoring Doctor and Mrs. Joseph A. Riggs

Wednesday, May 1, 1991

8:00 a.m. Registration Opens
8:00 a.m. Message Center Opens
8:30 a.m. Educational Program
1:00 p.m. Board of Trustees' Meeting

HOUSING APPLICATION

225th ANNUAL MEETING
THE MEDICAL SOCIETY OF NEW JERSEY
APRIL 28-MAY 1, 1991

Select the hotel of your choice. Mail the entire form with one night's deposit to that hotel.

TRUMP TAJ MAHAL CASINO/RESORT (Headquarters Hotel)

1000 BOARDWALK AT VIRGINIA AVENUE, ATLANTIC CITY, NJ 08401
RESERVATION DEPARTMENT 1-800-825-8786

(Please Print)

Name _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Business Phone _____

Sharing With _____

Date of Arrival _____ Time _____

Date of Departure _____ Time _____

A one-night deposit (equivalent to room rate) is required with all reservation requests. Please send check or money order payable to the **TRUMP TAJ MAHAL CASINO & RESORT** or complete the following:

Card # _____ Type _____ Exp. Date _____

SCHEDULE OF RATES SUBJECT TO 13% TAX

☐ SINGLE **$115** ☐ DOUBLE **$115** **(Reservations must be received prior to March 29, 1991)**
Extra Person **$25**

☐ One-Bedroom Suite **$275 per day**

☐ One-Bedroom Hospitality Suite **$275 per day**

Check-out time is 12 Noon. Rooms may not be available for check-in until after 3 p.m. Check-in time on Sundays is 5 p.m. FORTY-EIGHT (48) HOURS NOTICE OF CANCELLATION is required for a full refund.

PARKING: FREE PARKING TO REGISTERED GUESTS. One car per room.

☐ Check if Official Delegate _____ County _____

★★★

NOTEBOOK

TRUSTEES' MINUTES

A regular meeting of the Board of Trustees was held on December 16, 1990, at the executive offices in Lawrenceville. Detailed minutes are on file with the secretary of your county society. A summary of significant actions follows:

Report of the President . . . Announced the following: Robert V.P. Hutter is the 1991 recipient of the Edward J. Ill Award; Vincent A. Maressa is the 1991 recipient of the Academy of Medicine's Citizen's Award; and Doctors Arthur W. Perry and Louis G. Fares, III, are the recipents of the Professional Service Award.

Report of Executive Director . . .
(1) Financial Statements . . . Reviewed and approved the financial statements for the period ending November 30, 1990.
(2) Litigation . . . Noted the following: notices were sent to physicians who have not paid the $100 assessment, indicating the files will be forwarded to the Division of Taxation and this would involve a penalty—to avoid the penalty Mr. Maressa advised physicians to pay the assessment and indicate on the check that it is being "paid under protest"; and a decision in the malpractice surcharge case has not been rendered.
(3) Medicare Participation Agreements . . . Received a report prepared by the AMA Department of Federal Affairs regarding the sign-up process for the Medicare participating physician program.
(4) Ad Hoc Committee on Insurance Plan for the Elderly/ Medicare Alternative . . . Agreed to rescind the motion made at the November 18, 1990, meeting, and in lieu of the formation of an ad hoc committee, voted to refer the issue (to investigate and study the creation and operation of a private insurance plan for New Jersey elderly to replace Medicare Part B) to the Council on Medical Services for consideration and report back to the Board.
(5) Physician Assistants . . . Noted that MSNJ now will proceed to litigate the adoption of the physician assistants ruling by the State Board of Medical Examiners.
(6) MIIENJ Loan to MSNJ . . . Adopted the following resolution:

Resolved, that MSNJ be and hereby is authorized to borrow up to $2,795,000 ("the loan") from MIIENJ (the "lender") at an interest rate of 9 percent per annum for the purpose of constructing an 18,000-square-foot addition to the Society's headquarters facility in Lawrenceville, New Jersey, (the "premises"); and be it further

Resolved, that in order to secure the payment of the loan, the Society be and hereby is authorized to grant a mortgage to the lender encumbering the premises; and be it further

Resolved, that all acts heretofore taken by the president of the Society in furtherance of the transactions described in the foregoing resolutions are hereby ratified, confirmed, and adopted, and the president be and hereby is authorized to execute and deliver on behalf of the Society such promissory notes, mortgages, and other documents or instruments, and to do such other acts or things, as he deems necessary or appropriate to carry out the intent of the foregoing resolutions.

(7) MSNJ 800 NUMBER . . . Noted that the new telephone line (800/322-MSNJ) is in service.

Commissioner of Health . . . Noted that Doctor Frances Dunston addressed the Board and reiterated her interest in maintaining an ongoing dialogue with MSNJ.

Specialty Reports . . . Received reports from the University of Medicine and Dentistry, the New Jersey Hospital Association, and the Academy of Medicine of New Jersey.

Council on Legislation . . .
(1) State Legislation . . . Approved all the positions recommended by the Council on Legislation; a complete list of all the bills will appear in an upcoming issue of *NEW JERSEY MEDICINE.*

(2) Proposed Legislation . . . Approved the following recommendation for S-2584 (Consent, HIV Testing):

That MSNJ draft legislation making it possible for a physician to test for HIV sensitivity, without obtaining written consent, when medically indicated, given the confidentiality and other factors mentioned in S-2584.

(3) JEMPAC . . . Approved the following two recommendations:

That reminder notices be forwarded to the Council on Legislation, strongly urging all members of the Council to become sustaining members of JEMPAC.

That all members of councils and committees, as well as the Board of Trustees, be encouraged to join JEMPAC.

(4) Current Legislation . . . Approved all the positions recommended by the Council on Legislation, with the exception of the following: A-2984 (Notification/Agent Orange)—voted to refer the matter to the Council on Public Health for further study; S-3053 (Blood Transfusion)—voted to refer the matter for further study to the Council on Legislation, the New Jersey Society of Pathologists, the New Jersey Chapter of the American College of Surgeons, and the blood banks; and S-2051 (Dispensing of Drugs by Physicians)—approved the following recommendation: That the Medical Society support the efforts of dermatologists to include an exemption for topical medications.

Committee on Medicaid . . . Approved referral of the recommendation that the Uncompensated Care Trust Fund law be amended to include a mechanism for reimbursement for physicians' services back to the Committee on Medicaid.

Committee on Medical Aspects of Sports . . . Approved the following recommendation:

That the Medical Society of New Jersey adopt the policy that a physician covering athletic events should be a physician who is licensed to practice medicine and surgery in New Jersey and is CPR certified.

Committee on Biomedical Ethics . . . Approved the following:

Resolved, that the Medical Society of New Jersey urgently request that Governor James J. Florio and the state Legislature do everything in their power to provide adequate funding sufficient to permit the Commission on Legal and Ethical Problems in the Delivery of Health Care to continue its important work for the remainder of this fiscal year.

Unfinished Business . . .
(1) Administration of Medicare Program in New Jersey . . . Noted the response from Barbara J. Gagel, director of the Bureau of Program Operations, HCFA, noting: "I have been assured that the carrier's [Pennsylvania Blue Shield] overall performance remains sound, and that no broad-based deficiencies exist that would merit replacement of the carrier."
(2) Inspector General . . . Was supplied with a copy of the AMA letter summarizing the reasons for the resignation of Mr. Richard Kusserow, the inspector general for the Department of Health and Human Services.

New Business . . . Agreed to support the legislative efforts to strike the provision of the Budget Reconciliation Act that alters the reimbursement method for physicians who use EKGs. □

UMDNJ NOTES

UMDNJ Trustees Approve Nursing School. The University of Medicine and Dentistry of New Jersey (UMDNJ) Board of Trustees has approved the creation of a UMDNJ-School of Nursing, bringing to seven the number of schools in UMDNJ's statewide health sciences education network. The new UMDNJ-School of Nursing would be organized into three departments: certificate programs, associate degree programs, and baccalaureate and higher degree programs. The diversity of programs at the nursing school would create an "educational ladder." The ladder allows multiple entry and exit points, starting at the nursing assistant level and ending at the graduate level. The "rungs" on the ladder include nursing assistant, associate degree nurse, baccalaureate nurse, and master's degree nurse.

State Trails Nation in Reducing Heart Disease. New Jersey trails the national average in reducing deaths from a major form of heart disease, report scientists at UMDNJ-New Jersey Medical School, Newark. Consequently, New Jersey's statewide death rate from ischemic heart disease (IHD) is 29 percent higher than the national rate. The New Jersey rate is 168.5 deaths per 100,000 population, compared with 139.3 nationally. According to a study, IHD death rates in 18 of New Jersey's 21 counties exceeded the national average by as much as 56 percent. The study was conducted by Dr. G. Reza Najem, professor of preventive medicine and community health at the medical school, and published in the *International Journal of Epidemiology.* Dr. Najem attributed the state's IHD death rate to its extensive urbanization, industrialization, and population density.

Scientists Link Gene Mutation to Aneurysms. Researchers at UMDNJ-Robert Wood Johnson Medical School, New Brunswick, have discovered a gene mutation responsible for causing some types of aneurysms, a blood-vessel defect that kills thousands of elderly Americans annually. The research, which found the mutation in type-III collagen, is the first to link the mutation with a relatively common disorder. The UMDNJ researchers have been awarded a $161,000 three-year grant from Johnson & Johnson to continue their investigation into the genetic mutation. One of the goals of the work is to develop a simple blood test that would reveal the genetic abnormality early enough for physicians to take preventive measures. The research is being conducted by Drs. Charles Boyd and Susan Deak of the Molecular Biology Research Group of the Department of Surgery. The researchers examined tissue samples from patients with aortic or multiple aneurysms. By employing sophisticated techniques involving recombinant DNA, known as gene splicing, and protein chemistry, they traced the structural defect to the genetic mutation.

Dieting Is Prescribed Following Gastric Reduction Surgery.

Morbidly obese patients who lose at least half of their excess weight after stomach-stapling surgery significantly increase their chances of living longer, healthier lives. Research conducted by Dr. Robert Brolin, professor of surgery at the UMDNJ-Robert Wood Johnson Medical School, New Brunswick, revealed that weight loss following gastric reduction surgery, which involves stomach stapling, significantly decreases the amount of fat (lipids) in the patient's blood. Abnormally high blood-lipid levels lead to a variety of cardiovascular complications such as diabetes, heart attacks, and strokes. All are potentially life-threatening, especially to the morbidly obese—those who weigh at least 100 pounds over their ideal body weight. Gastric-stapling surgery limits the amount of food patients can eat at one time but it is up to the patients to eat wisely. If they eat the right foods, they can reverse high lipid levels that contribute to life-threatening conditions.

New Dental Lab Includes Advanced Mannequin Heads. First- and second-year dental students are not allowed to work on live patients. But at UMDNJ-New Jersey Dental School, Newark, they practice on the next best thing—mannequins. State-of-the-art mannequin heads, that closely resemble the human mouth, face, and jaw in shape and texture, are the mainstay of the school's new $1.2 million teaching laboratory. The laboratory, only the third of its kind in North America, helps beginning dental students treat patients by practicing on inanimate objects. □ Stanley S. Bergen, Jr., MD, President

MSNJ AUXILIARY

Reorganization is the magic word for a group of physicians' spouses in Monmouth County. Susan Kahn, wife of the Monmouth County Medical Society president, is spearheading the drive to reorganize the Auxiliary after a ten-year inactive period. A reorganization meeting, held in December, was attended by over 30 physicians' spouses and MSNJA officers, Jane Lorber, Jean Taboada, and Marion Geib. Prospective members shared thoughts on the purpose and role of the Auxiliary and the necessity to get together once again to support the causes of the medical profession.

From other county auxiliaries come reports of successful health projects, legislative activities, and fundraisers for charity. In Burlington County, monies were donated to Provident House, a shelter for battered women, and to Crossroads, a haven for sexually abused and runaway children. Future plans include a program called "Love the Children," that helps Vietnamese youngsters with health-related problems and also provides medical supplies. Camden County auxiliary members donated eight new car seats to the three county hospitals as part of their Baby Safe Ride Program. The Cape May Auxiliary's Infant Car Seat Program is thriving and plans are underway to support the new Burdette Tomlin Memorial Hospital Day Care Center. Cape May Auxiliary members also are supporting a group from the Upper Township School District and its "Safe Home" program—a program in which parents sign a contract stating they will be present at all parties held in their homes, and that no underage drinking will occur. In Gloucester County, a breast screening was sponsored by the Auxiliary and the Underwood-Memorial Hospital; the Hospital's general surgeons examined over 70 patients. Members of the Mercer County Auxiliary and friends sponsored a career program for talented and gifted inner-city fifth and sixth graders at the Stuart Country Day School's "Stars" summer camp in Princeton. The group provided a look at the working world—understanding careers and occupations by thinking about data, people, ideas, and things. Auxiliary members discussed their various occupations: professional writing, college teaching, psychology, veterinary science, and nursing. In the interest of public health and deficit reduction, Passaic County Auxiliary members contacted United States senators and members of the House of Representatives urging them to support the increase in excise taxes on alcohol and tobacco. Their legislative lobbying was in support of the AMA position that the consumption of alcohol and tobacco contribute significantly to increased health care costs borne by both the federal government and taxpayers. Union County's Car Seat Loan Program is functioning well. They are exploring the possibility of purchasing some of the specialized car seats, the "Swinger" and the "Spica Seats," for the Children's Specialized Hospital in Mountainside. Warren County Auxiliary participated in the "Countdown America Cholesterol Screening" held at Warren Hospital; auxiliary members staffed registration, took blood pressures, and gave the program full support.

At the state level, the Auxiliary is planning legislative trips to Trenton and Washington, DC. □ Marion H. Geib

NEW MEMBERS

The Medical Society of New Jersey would like to welcome the following new members:

Bergen County
Fred M. Carter, II, MD
Mario V. Magasic, MD

Burlington County
Craig S. Kimmel, MD
Betsy L. Schloo, MD

Camden County
John W. Ashby, MD
Steven P. Baughn, MD
Jeffrey B. Daniels, MD

Gary N. Goldstein, MD
Robert S. Marcello, MD
Mary C. O'Brien, MD
Jeffrey H. Oppenheimer, MD
Joanne Swift, MD
Theodore W. Wasserman, MD

Essex County
Lawrence O. Egbuchulam, MD
George Z. Farion, MD
Charles E. Granatir, MD
Jan A. Huston, MD
Donald J. Mac Pherson, MD
Lawrence F. Mahdi, MD
Susan H. Morrison, MD
Lillian F. Pliner, MD
Steven G. Robbins, MD
Michael A. Sbarra, MD
Sarwan K. Seth, MD
Richard B. Shoenfeld, MD

Gloucester County
Bruce M. Klein, MD
Emanuel Lamprou, Jr., MD
Todd M. Lipschultz, MD

Mercer County
David R. Hertzog, MD
Andrew J. Pedinoff, MD

Middlesex County
Steven H. Friedland, MD
Edward von der Schmidt, III, MD

Morris County
Peter E. Gallerstein, MD
Cory A. Golloub, MD
Isaac Starker, MD
Robert L. Steer, MD

Passaic County
Steven W. Domnitz, MD
Howard P. Gliklich, MD
Chaim E. Rosen, MD
Allen H.B. Yu, MD

Somerset County
Gary A. Drascher, MD
Glenn T. Friedman, MD

Union County
Patrick V. Aufiero, MD
Barry R. Ellman, MD
Roy E. Naturman, MD
Marlan K. Schwartz, MD
Lata R. Shah, MD

PLACEMENT FILE

The following physicians have written to the executive offices of MSNJ seeking information on possible practice opportunities in New Jersey. The information listed below has been supplied by the physicians. If you are interested in any further information concerning these physicians, we suggest you make inquiries directly to them.

ANESTHESIOLOGY

Michael Silverberg, MD, 2020 Walnut St., Apt. 29K, Philadelphia, PA 19103. Yale 1983. Board eligible. Group or hospital. Available July 1991.

CARDIOLOGY

George D. Birmingham, MD, 3531 Salerno Ct., Apt. 5, Middleton, WI 53562. Mount Sinai 1984. Board eligible. Board certified (IM). Group or partnership. Available July 1991.

INTERNAL MEDICINE

Won-Kook Chung, MD, 70 Hampshire Dr., Plainsboro, NJ 08536. Catholic Medical College (Korea). Board eligible. Group or solo. Available July 1991.

Thomas P. Hooker, DO, 2804 Sitios St., Tampa, FL 33629. Philadelphia College of Osteopathic Medicine 1984. Board certified; also, PUL. Solo or multispecialty group. Available July 1991.

Marc Kesselhaut, MD, 1 Rustic Ridge, C16, Little Falls, NJ 07424. St. George's University 1986. Board eligible. Solo or partnership in Mercer, Somerset, Burlington, Hunterdon, or Middlesex counties. Available.

PATHOLOGY

Charles F. Romberger, MD, 4501 Park Glen Rd., #241, St. Louis Park, MN 55416-4874. Temple 1986. Board eligible. Partnership or group. Available.

PEDIATRICS

Donna Churlin, MD, 55 Montgomery St., Bloomfield, NJ 07003. UMDNJ 1987. Board eligible. Partnership or group in central New Jersey (Essex, Union, or Morris counties). Available July 1991.

UROLOGY

Jeffrey L. Gevirtz, MD, 400 Narragansett Pkwy., Apt. SC7, Warwick, RI 02888. UMDNJ-Robert Wood Johnson Medical School 1986. Board eligible. Group or partnership. Available July 1991.

S. Misra, MD, 8161 Gatewood Dr., Clay, NY 13041. SCB-Orissa (India) 1977. Board eligible. Group or partnership. Available July 1991.

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ANESTHESIOLOGY

March

16-17 **32nd Annual Postgraduate Anesthesia Seminar**
All day—The Hyatt, Cherry Hill
(NJ State Society of Anesthesiologists)

CARDIOLOGY

March

6 **Indications for Noninvasive Studies**
10:30-11:30 A.M.—Christ Hospital, Jersey City
(AMNJ)

8 **Newer Cardiac Drugs**
1-2 P.M.—North Princeton Developmental Center, Princeton
(AMNJ)

DERMATOLOGY

March

12 **Dermatology Meeting**
7-9 P.M.—Schering Corporation, Kenilworth
(Dermatological Society of New Jersey)

14 **Update on Superficial Fungal Infections**
10-11 A.M.—Hunterdon Developmental Center, Clinton
(AMNJ)

20 **Case Presentations**
6 P.M.—Rutgers Community Health Plan, U.S. Route 1, New Brunswick
(UMDNJ, Division of Dermatology)

April

9 **Retinoids**
7-9 P.M.—Schering Corporation, Kenilworth
(Dermatological Society of New Jersey)

17 **Case Presentations**
6 P.M.—Rutgers Community Health Plan, U.S. Route 1, New Brunswick
(UMDNJ, Division of Dermatology)

INFECTIOUS DISEASE

March

4 **Diagnosis and Treatment of AIDS**
1-2 P.M.—New Lisbon Developmental Center, New Lisbon
(AMNJ and NJDOH)

April

10 **Identification and Management of HIV-Infection**
9-10 A.M.—Elizabeth General Medical Center, Elizabeth
(AMNJ and NJDOH)

10 **AIDS Training for Hospital Health Educators**
2:30-3:30 P.M.—Ancora Psychiatric Hospital, Hammonton
(AMNJ and NJDOH)

MEDICINE

March

1 **19th Annual Joint Conference**
8 A.M.-4 P.M.—Hyatt Regency, New Brunswick
(NJ Thoracic Society/NJ Chapter, American College of Chest Physicians)

5-26 **Internal Medicine Update and Board Review**
5:30-7:30 P.M.—Cooper Hospital/University Medical Center, Camden
(Cooper Hospital/University Medical Center)

6 **Calcium Channel Blockers and Hypertension**
1:30-2:30 P.M.—Central New Jersey Medical Group, New Brunswick
(AMNJ)

6 **Diabetic Retinopathy**
9-10 A.M.—Warren Hospital, Phillipsburg
(AMNJ)

6-27 **Internal Medicine Review Course**
4-7 P.M.—University Hospital, New Brunswick
(AMNJ and UMDNJ)

6 **Endocrine Grand Rounds**
13-27 11:30 A.M.-1 P.M.—VA Medical Center, East Orange
(AMNJ)

6 **Interhospital Endocrine Rounds**
13-27 3:30-5 P.M.—University Hospital, Newark
(AMNJ)

6 **Dinner Meeting**
6-9 P.M.—Holiday Inn, Newark Airport
(Endocrinology Section, AMNJ)

13 **Treating Medical Disorders in People with Developmental Disabilities**
11:30 A.M.-12:30 P.M.—Rahway Hospital, Rahway
(AMNJ)

13 **Diabetic Retinopathy**
12 Noon-1 P.M.—Union Hospital, Union
(AMNJ)

13 **CDS Prescribing Practices: Legal/Illegal**
10:30 A.M.-12 Noon—Christ Hospital, Jersey City
(AMNJ)

13 **Diabetic Nephropathy**
8-9 A.M.—Barnert Hospital, Paterson
(AMNJ)

15 **Mitral Valve Prolapse in Panic and Eating Disorders**
10-11:30 A.M.—Marlboro Psychiatric Hospital, Marlboro
(AMNJ)

18 **Functional Assessment of the Elderly**
11:30 A.M.-1 P.M.—East Orange General Hospital, East Orange
(AMNJ)

19 **Congenital Adrenal Hyperplasia**
8 A.M.—St. Joseph's Hospital and Medical Center, Paterson
(St. Joseph's Hospital and Medical Center)

19 **Adverse Reactions to Hemodialysis**
6:30-9:30 P.M.—Overlook Hospital, Summit
(Nephrology Society of New Jersey)

20 **Approach to Testing for Hearing Loss**
1:30-2:30 P.M.—Central New

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"Physiology of Respiration During Sleep"
Robert A. Capone, M.D., FCCP
Medical Director, Sleep Disorder Center of Greater New Jersey

"Clinical Aspects of Sleep Apnea Syndromes"
David M. Rapoport, M.D., FCCP
Medical Director, Bellevue Sleep Laboratory, New York, NY

"Treatment of Obstructive Sleep Apnea with CPAP & BiPAP"
Mark H. Sanders, M.D., FCCP
Director, Pulmonary Sleep Evaluation Laboratory, Presbyterian-University Hospital, Pittsburgh, PA

"Surgical Treatment of Obstructive Sleep Apnea"
Department of Otolaryngology,
Morristown Memorial Hospital

"Sleep and Other Respiratory Disorders"
Mark J. Atkins, M.D., FCCP
Instructor, Clinical Medicine, Columbia University
Attending Physician, Morristown Memorial Hospital

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(UMDNJ)

22 Treating Medical Disorders in People with Developmental Disabilities
12 Noon-1 P.M.—South Jersey Hospital System, Bridgeton
(AMNJ)

26 Management of Intractable Epilepsy
8 A.M.—St. Joseph's Hospital and Medical Center, Paterson
(St. Joseph's Hospital and Medical Center)

27 Diabetic Retinopathy
1:30-2:30 P.M.—Essex County Hospital Center, Cedar Grove
(AMNJ)

28 Visiting Professor Lecture
1:30-5 P.M.—Saint Barnabas Medical Center, Livingston
(Saint Barnabas Medical Center)

April

2-9-16-23-30 Internal Medicine Update and Board Review
5:30-7:30 P.M.—Cooper Hospital/University Medical Center, Camden
(Cooper Hospital/University Medical Center)

2 Chromium: Environmental Contamination as a Potential Occupational Hazard
12:15-1:30 P.M.—John Fitch Plaza, Trenton
(AMNJ)

3 Malpractice Insurance
10:30-11:30 A.M.—Christ Hospital, Jersey City
(AMNJ)

3-10-17-24 Internal Medicine Review Course
4-7 P.M.—University Hospital, New Brunswick
(AMNJ and UMDNJ)

5 Diabetes in Pregnancy
12 Noon-1 P.M.—South Jersey Hospital System, Bridgeton
(AMNJ)

10 Prevention of Lower Extremity Amputations
2-3 P.M.—Welkind Rehabilitation Center, Chester
(AMNJ)

10 CDS Prescribing Practices: Legal/Illegal
10:30-11:30 A.M.—St. Mary's Hospital, Passaic
(AMNJ)

10 New Developments in Emergency Care in New Jersey
10:30-11:30 A.M.—Christ Hospital, Jersey City
(Jersey City)

11-14 39th Annual Meeting and Scientific Assembly: New Jersey Academy of Family Physicians
Caesar's Atlantic Hotel and Casino, Atlantic City
(NJ Academy of Family Physicians)

12 Arthritis
1-2 P.M.—North Princeton Developmental Center, Princeton
(AMNJ)

12 Diabetic Retinopathy
8:30-9:30 A.M.—United Hospitals Medical Center, Newark
(AMNJ)

16 Renal Failure and Brain Function
6:30-9:30 P.M.—Overlook Hospital, Summit
(Nephrology Society of New Jersey)

17 Calcium Absorption, Abnormalities of Calcium, and Vitamin D Metabolism
10:30-11:30 A.M.—St. Mary's Hospital, Passaic
(AMNJ)

17 Autologous Blood Transfusion
10:30 A.M.-12 Noon—Christ Hospital, Jersey City
(AMNJ)

17 Diabetes and Cardiovascular Diseases
1:30-2:30 P.M.—Central New Jersey Medical Group, New Brunswick
(AMNJ)

18 Anemia in the Elderly
1:30-2:30 P.M.—Essex County Hospital Center, Cedar Grove
(AMNJ)

22 Prevention of Lower Extremity Amputations
1-2 P.M.—New Lisbon Developmental Center
(AMNJ)

23 Changing Nature of Health Care Economics
8 A.M.—St. Joseph's Hospital and Medical Center, Paterson
(St. Joseph's Hospital and Medical Center)

24 New Treatments in Cerebrovascular Disease
1:30-2:30 P.M.—Runnells Specialized Hospital, Berkeley Heights
(AMNJ)

24 Nutritional Support
10:30-11:30 A.M.—Christ Hospital, Jersey City
(AMNJ)

24 Fluid Electrolyte Imbalance
2:30-3:30 P.M.—Trenton Psychiatric Hospital, Trenton
(AMNJ)

25 Pain Therapy
12 Noon-1 P.M.—Centrastate Medical Center, Freehold
(AMNJ)

26 Mental Retardation Journal Club
11:30 A.M.-12:30 P.M.—Hunterdon Developmental Center, Clinton
(AMNJ)

26-27 Controversial Issues in Preventive Medicine
All day—Trump Regency, Atlantic City
(Cooper Hospital/University Medical Center)

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Women and Coronary Heart Disease

Moderator: Bernard L. Segal, M.D.

3:00-3:30	The diagnosis and management of ischemic heart disease in women	*Michael S. Feldman, M.D.*
3:30-4:00	Coronary artery bypass surgery in women	*James D. Sink, M.D.*
4:00-5:00	Case Presentations	*Thach N. Nguyen, M.D.*
	Panel Discussion	*Philip A. Bhark, M.D.*
	Michael S. Feldman, M.D.	*Marvin Rosner, D.O.*
	William J. Untereker, M.D.	*Jan R. Weber, M.D.*

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OBSTETRICS/GYNECOLOGY

March

1-3 **Annual Semmelweis Waters Ob/Gyn**
8 A.M.-5 P.M.—Bally's Park Place Casino, Atlantic City
(UMDNJ)

5 **Obstetrical Practices in New Jersey**
12:15-1:30 P.M.—John Fitch Plaza, Trenton
(AMNJ)

12 **Pregnancy-Related Mortality in New Jersey**
12:15-1:30 P.M.—John Fitch Plaza, Trenton
(AMNJ)

13 **Diabetes in Pregnancy**
9-10 A.M.—Elizabeth General Medical Center, Elizabeth
(AMNJ and NJDOH)

April

3 **Common Gynecological Problems**
1:30-2:30 P.M.—Central New Jersey Medical Group, New Brunswick
(AMNJ)

5 **Diabetes in Pregnancy**
12 Noon-1 P.M.—South Jersey Hospital System, Bridgeton
(AMNJ)

11-13 **Cutting Edge '91: Information Update**
Ocean Plaza Hilton Resort Spa, Long Branch
(Monmouth Medical Center)

ONCOLOGY

March

6 **12th Annual Tumor Board Conference**
6-9 P.M.—MSNJ Headquarters, Lawrenceville
(Oncology Society of New Jersey)

8 **Tumor Board**
11 A.M.-12 Noon—Wallkill Valley Hospital, Sussex
(AMNJ)

27 **Reception**
6:30-9:30 P.M.—The Manor, West Orange
(Radiation Oncology Section, AMNJ)

28 **Tumor Board Conference**
12 Noon-1 P.M.—Newcomb Medical Center, Vineland
(AMNJ)

April

18 **Dinner Meeting**
6:30-9:30 P.M.—The Hyatt, New Brunswick
(Head and Neck Section, AMNJ)

ORTHOPEDICS

April

16-21 **Annual Spring Meeting**
Walt Disney World Swan Hotel, Orlando, Florida
(NJ Orthopedic Society)

PATHOLOGY

March

11 **Clinical Pathology Conference**
7:30 A.M.—St. Joseph's Hospital and Medical Center, Paterson
(St. Joseph's Hospital and Medical Center)

PEDIATRICS

March

1-2 **Advanced Life Support Course**
7:30 A.M.-4:30 P.M.—Shore Memorial Hospital, Somers Point
(AMNJ)

28 **Update in Pediatrics**
6:30-10 P.M.—Marriott Hotel, Saddle Brook
(AMNJ)

April

16 **Pediatric AIDS in the Soviet Union**
12:15-1:30 P.M.—John Fitch Plaza, Trenton
(AMNJ)

19 **Juvenile Onset Diabetes**
12 Noon-1 P.M.—South Jersey Hospital System, Bridgeton
(AMNJ)

25 **Update in Pediatrics**
6:30-10 P.M.—Marriott Hotel, Saddle Brook
(AMNJ)

26 **Current Concepts in Pediatric Hematology-Oncology**
9 A.M.-3 P.M.—Hyatt Regency, New Brunswick
(The Valerie Fund Children's Center and AMNJ)

PSYCHIATRY

March

15 **Management of Patients with Chronic Aggression**
10-11 A.M.—Marlboro Psychiatric Hospital, Marlboro
(AMNJ)

26 **Suicide**
1:30-3:30 P.M.—Trenton Psychiatric Hospital, Trenton
(AMNJ)

April

4 **Anticonvulsants in the Treatment of Mania**
12 Noon-1 P.M.—Carrier Foundation, Belle Mead
(Carrier Foundation)

11 **Serotonergic Dysregulation in Aggression—Clinical Implications**
12 Noon-1 P.M.—Carrier Foundation, Belle Mead
(Carrier Foundation)

18 **Research Update: Substance Abuse**
12 Noon-1 P.M.—Carrier Foundation, Belle Mead
(Carrier Foundation)

23 **The Violent Patient**
1:30-3:30 P.M.—Trenton Psychiatric Hospital, Trenton
(AMNJ)

24 **Psychosexual Disorders**
All day—Carrier Foundation, Belle Mead
(Carrier Foundation)

RADIOLOGY

March

6 **Nuclear Medicine**
10:30-11:30 A.M.—St. Mary's Hospital, Passaic
(AMNJ)

14 **MRI of the Abdomen**
7:30-9:30 P.M.—Saint Barnabas Medical Center, Livingston
(Radiological Society of NJ/ AMNJ)

21 **Radiology Meeting**
Saint Barnabas Medical Center, Livingston
(Radiology Society of NJ/AMNJ)

April

11 **Radiology Meeting**
7:30-9:30 P.M.—Saint Barnabas Medical Center, Livingston
(Radiology Society of NJ/AMNJ)

SURGERY AND ITS SPECIALTIES

March

13 **High-Risk Surgery**
10:30-11:30 A.M.—St. Mary's Hospital, Passaic
(AMNJ)

20 **13th Annual Meeting**
1:30-5 P.M.—Cooper Hospital/ University Medical Center, Camden
(Vascular Society of New Jersey)

UROLOGY

March

20 **Transurethral Resection**
10:30-11:30 A.M.—St. Mary's Hospital, Passaic
(AMNJ)

HU

Hahnemann University

Department of Medicine Grand Rounds 8:30 a.m.-9:30 a.m.

February 1991-May 1991

FEBRUARY 1991

February 6, 1991
SYPHILIS, NEUROSYPHILIS, PENICILLIN AND AIDS
Daniel M. Musher, MD
Professor of Medicine
Microbiology and Immunology
Baylor College of Medicine;
Chief, Infectious Diseases Section
Veterans Administration Medical Center

February 13, 1991
ERYTHROPOIETIN: RESPONSIBLE FOR RBC PRODUCTION AND SURVIVAL
Allan B. Schwartz, MD
Professor of Medicine
Hahnemann University

February 20, 1991
GASTROINTESTINAL INFECTIONS
Sherwood L. Gorbach, MD
Chief, Infectious Disease Section
New England Medical Center
Boston, Massachusetts

February 27, 1991
TREATMENT OF BREAST CANCER
Martin Abeloff, MD
Professor of Medicine
Chief of Medical Oncology
Johns Hopkins Oncology Center
Baltimore, Maryland

MARCH 1991

March 6, 1991
CLINICAL PATHOLOGICAL CONFERENCE CHIEF MEDICAL RESIDENTS PRESENTATIONS
Marc Grobman, DO
An Pham, MD
Karen Tom, MD
Department of Medicine
Hahnemann University

March 13, 1991
A VIEW OF CORONARY REVASCULARIZATION
Robert L. Frye, MD
Professor and Chairman
Department of Medicine
Division of Cardiology, Mayo Clinic
Rochester, Minnesota

March 20, 1991
OPHTHALMOLOGY FOR THE INTERNIST, SYSTEMATIC DISEASE AS SEEN THROUGH THE EYE
Stephen Sinclair, MD
Professor of Ophthalmology
Vice Chairman, Department of Ophthalmology
Hahnemann University
Elliot Werner, MD
Associate Professor of Ophthalmology
Director, Glaucoma Service
Hahnemann University

March 27, 1991
NEW DERMATOLOGIC ANTIFUNGAL AGENTS FOR CUTANEOUS INFECTIONS
Edgar B. Smith, MD
Professor and Chairman
Department of Dermatology
University of Texas, Medical Branch
Galveston, Texas

CUTANEOUS STAPHYLOCOCCUS AUREUS INFECTIONS IN AIDS PATIENTS
James J. Leyden, MD
Professor of Dermatology
University of Pennsylvania
Philadelphia, Pennsylvania

APRIL 1991

April 3, 1991
GENE THERAPY
William N. Kelley, MD
Executive Vice President of the University of Pennsylvania
CEO, University of Pennsylvania Medical Center
Dean, University of Pennsylvania School of Medicine

April 10, 1991
NEW OPTIONS IN HEART FAILURE THERAPY
Marc A. Pfeffer, MD, PhD
Cardiovascular Division
Brigham and Women's Hospital
Boston, Massachusetts

April 17, 1991
RHEUMATOLOGIC ADVANCES
William J. Koopman, MD
H.L. Holley Professor of Medicine
Director, Division of Clinical Immunology and Rheumatology; Director, Multipurpose Arthritic Center
University of Alabama/Birmingham

April 24, 1991
ANTIHYPERTENSIVE THERAPY: BENEFITS BEYOND BLOOD PRESSURE CONTROL
Randall Zussman, MD
Assistant Professor of Medicine
Director, Division of Hypertension and Vascular Medicine
Massachusetts General Hospital
Boston, Massachusetts

MAY 1991

May 1, 1991
CHRONIC BRONCHITIS: A SYNDROME WE THOUGHT WE UNDERSTOOD
Stephen Rennard, MD
Larson Professor of Medicine
Section Chief, Pulmonary and Critical Care Medicine
University of Nebraska
Omaha, Nebraksa

May 8, 1991
To Be Announced

May 15, 1991
HEPATORENAL SYNDROME
Murray Epstein, MD
Professor of Medicine
University of Miami School of Medicine
Associate Director, Nephrology Section
Veterans Administration Medical Center
Miami, Florida

May 22, 1991
ADENOSINE: A NEW ANTIARRHYTHMIC DRUG
Bruce B. Lerman, MD
Director, Clinical Electrophysiology
Division of Cardiology
New York Hospital/Cornell Medical Center
New York, New York

May 29, 1991
CHOLELITHIASIS—NEWEST MEDICAL AND SURGICAL TREATMENTS
Teruo Matsumoto, MD, PhD
Professor of Surgery
Hahnemann University
Harris R. Clearfield, MD
Professor of Medicine
Director, Division of Gastroenterology
Hahnemann University

Hahnemann University Department of Medicine
Wednesday Medical Seminar Series
8:30 AM-3:30 PM

February 20, 1991
DIAGNOSIS AND TREATMENT OF GASTROINTESTINAL INFECTIONS

March 27, 1991
TRENDS IN TREATMENT OF CUTANEOUS INFECTIONS

April 10, 1991
NEW OPTIONS IN HEART FAILURE THERAPY

April 17, 1991
RHEUMATOLOGIC ADVANCES

May 15, 1991
KIDNEY DISEASE, FLUID & ELECTROLYTES

Seminar Directors:

William S. Frankl, MD
Professor of Medicine
and Chairman
Department of Medicine

Allan B. Schwartz, MD
Professor of Medicine
Director, Continuing Medical Education
for the Department of Medicine

Location:

Classroom C (Alumni Hall)
2nd Fl. New College Bldg.
Hahnemann University (15th Street Entrance)
15th and Vine Streets, Philadelphia, PA

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IN MEMORIAM

Joan M. Arboit. A member of our Essex County component and a resident of Montclair, Joan Marie Arboit, MD, died at the untimely age of 54. Dr. Arboit was born in Brooklyn on May 1, 1936; she died October 19, 1990. In 1961, Dr. Arboit received her medical degree from McGill University Faculty of Medicine, Montreal, Canada. Dr. Arboit interned at the University of Illinois Research and Educational Hospital, Chicago, from 1961 to 1962, followed by residencies at the University of Illinois Research and Educational Hospital from 1962 to 1963 and at New York Hospital, Cornell University from 1963 to 1964, both in pediatrics. Dr. Arboit received her New York and New Jersey medical licenses in 1963 and in 1966, respectively. Dr. Arboit maintained a private pediatrics practice in Nutley. Dr. Arboit was affiliated with the former Harrison S. Martland Memorial Center, Newark; Clara Maass Medical Center, Belleville; Rahway Hospital; Saint Barnabas Medical Center, Livingston; Elizabeth General Medical Center; Morristown Memorial Hospital; and Newark Beth Israel Medical Center. Dr. Arboit was an associate clinical professor at UMDNJ, Newark. A diplomate of the American Board of Pediatric Nephrology, Dr. Arboit was a fellow of the American Academy of Pediatrics, and a member of the American Medical Association and of the American Society of Pediatric Nephrology.

Ellwood W. Godfrey. At the age of 79, Ellwood Watson Godfrey, MD, a retired member of our Mercer County component, died on June 10, 1990. Born in Ambler, Pennsylvania, on July 17, 1910, Dr. Godfrey earned his medical degree from the University of Pennsylvania School of Medicine, Philadelphia, in 1937. After graduation he was affiliated with the University of Pennsylvania Medical School as an associate radiologist. From 1942 to 1946, Dr. Godfrey served in the United States Navy with a terminal rank of commander. In 1952, he received his New Jersey medical license and was appointed to the Department of Radiology at The Medical Center at Princeton. Dr. Godfrey was a diplomate of the American Board of Radiology and a fellow of the American College of Radiology. In 1982, Dr. Godfrey retired to Vero Beach, Florida, where his wife still resides.

John Insabella. An ophthalmologist in Essex County for over 50 years, John Insabella, MD, died on October 16, 1990, at the age of 76. Dr. Insabella was born in Newark on December 6, 1913, and resided in West Orange, Allenhurst, and Newark and maintained a private practice in Newark and later practiced with the Northern New Jersey Eye Institute, South Orange. Dr. Insabella received his medical degree from the University of St. Louis, Missouri, in 1939, interned at Saint Michael's Medical Center, Newark, served a residency at Newark Eye and Ear Infirmary, and received his New Jersey medical license in 1946. Dr. Insabella also completed postgraduate courses at Polyclinic Hospital, New York, and at New York Eye and Ear Infirmary. Dr. Insabella was affiliated with Saint Michael's Medical Center, Newark; the former Harrison S. Martland Medical Center, Newark; Newark Eye and Ear Infirmary; Saint Barnabas Medical Center, Livingston; and The Hospital Center at Orange. Dr. Insabella was an ophthalmology professor at the University of Medicine and Dentistry of New Jersey, Newark, and served as a school physician for the Newark Board of Education. Dr. Insabella was a diplomate of the American Board of Ophthalmology and a fellow of the American College of Surgeons. In addition, Dr. Insabella was a member of the American Medical Association, of our Essex County component, and of the Northern New Jersey Ophthalmology Society. Dr. Insabella was awarded the Medical Society of New Jersey's distinguished service award in 1989. During World War II, Dr. Insabella was a flight surgeon with the Army Air Corps.

Dean W. Marquis. Retired Essex County member, Dean Wilson Marquis, MD, died on June 29, 1990, in Palm Beach, Florida. Born on December 12, 1900, in Cedar Falls, Iowa, Dr. Marquis received his medical degree from Cornell University Medical College, New York, in 1926. A resident of Short Hills, Dr. Marquis was affiliated with the Department of Internal Medicine at the Hospital Center at Orange. Dr. Marquis was a member of the American Medical Association, of the American College of Physicians, of the American Academy of Allergy, of

the New York Academy of Medicine, and of the Academy of Medicine of New Jersey. During World War II, Dr. Marquis was a commander for the U.S. Navy.

John P. Mohair. At the age of 82, John Paul Mohair, MD, died on August 8, 1990. Dr. Mohair was born in Hasbrouck Heights on January 20, 1908, and was retired since 1976. Dr. Mohair graduated with a medical degree from Georgetown University School of Medicine, Washington, DC, in 1932, and received his New Jersey medical license the following year. A psychiatrist, Dr. Mohair served as director of the psychiatric clinic at the State Home for Boys, Jamesburg, as an associate at Monmouth Medical Center, Long Branch, and as a medical director at Ocean Mental Health Clinic, Toms River. Dr. Mohair resided in Matawan and Lakewood. Dr. Mohair was a member of our Monmouth County component, of the American Medical Association, of the New Jersey Psychiatric Society, and of the American Psychiatric Association. From 1952 to 1954, Dr. Mohair was a United States Navy commander.

Douglas W. Payne. Board certified in obstetrics and gynecology, Douglas W. Payne, MD, passed away at the age of 73; he died on August 23, 1990. Dr. Payne was born March 11, 1917, in Edmond, Oklahoma, and earned his medical degree from the University of Oklahoma School of Medicine, Oklahoma City, in 1942. After interning from 1942 to 1943 at the former Fitkin Memorial Hospital, Neptune, Dr. Payne served as a lieutenant in the United States Navy from 1943 to 1946 and earned his New Jersey medical license in 1946. Dr. Payne then served residencies at the former French Hospital, New York City, and at Cooper Hospital/University Medical Center, Camden, from 1947 to 1948 and 1949 to 1950, respectively. Dr. Payne was affiliated with the former Fitkin Memorial Hospital, Monmouth Medical Center, Long Branch, and Jersey Shore Medical Center, Neptune. Dr. Payne was a member of our Monmouth County component and of the American Medical Association. He was a fellow of the American College of Surgeons and of the American College of Obstetricians and Gynecologists. Dr. Payne resided in Interlaken and retired to Palm Beach, Florida.

William S. Schram. Word has been received of the death of psychiatrist William S. Schram, MD, at the age of 81. Dr. Schram was born in Newark on September 5, 1908, and passed away February 3, 1990. After graduating from the Royal Medical College, Glasgow, Scotland, with a medical degree in 1939, Dr. Schram maintained a practice in Westfield. Dr. Schram was affiliated with the former Essex County Overbrook Hospital, Cedar Grove; and Veterans Administration Medical Center, Lyons. Dr. Schram was a member of our Essex County component, of the American Medical Association, and of the New Jersey Neuropsychiatric Association. Dr. Schram also was a fellow of the American Psychiatric Association. Dr. Schram served in the United States Army as a neuropsychiatrist during World War II. Dr. Schram lived in Bloomfield.

Frederick Sheer. Obstetrician-gynecologist Frederick Sheer, MD, died on October 15, 1990, at the age of 82. Born in London, England, Dr. Sheer was awarded his medical degree from New York University School of Medicine, New York, in 1931. He completed an internship at Beth Moses Hospital, Brooklyn, New York, in 1933. Dr. Sheer resided in Brooklyn, and was a clinical instructor and assistant professor in obstetrics and gynecology at Downstate Medical Center, State University of New York. While practicing in New York, Dr. Sheer was affiliated with Maimonides Hospital, St. John's Hospital, Cumberland Street Hospital, Coney Island Hospital, and Caledonian Hospital, all in Brooklyn. In 1981, Dr. Sheer was honored with a 50-year service citation by the Medical Society of the State of New York and also received the New York University School of Medicine 50th Anniversary Certificate for service to the profession, the school, and the community. In 1984, Dr. Sheer received his license to practice medicine in New Jersey. Active in organized medicine, Dr. Sheer was a diplomate of the American Board of Obstetrics and Gynecology, and a member of our Middlesex County component, of the American Medical Association, of the American College of Surgeons, and of the American and International Colleges of Obstetricians and Gynecologists. During World War II, Dr. Sheer was a captain in the medical corps of the United States Army.

Wieslawa K. Trzaskowski. Word has been received of the death of Wieslawa Krystyna Trzaskowski, MD, on October 24, 1990. Born in Poland in 1931, Dr. Trzaskowski received a doctor of philosophy degree and a medical degree from the Medical Academy, Krakow, Poland, in November 1955. After completing a residency at the Medical Academy Hospital in 1962, Dr. Trzaskowski was a pediatrician in Poland; she was a member of the Polish Pediatrics Society for 15 years. In 1980, Dr. Trzaskowski immigrated to the United States and completed a training program at Jersey Shore Medical Center, Neptune; she received a license to practice medicine in New Jersey in 1983. Dr. Trzaskowski was a member of our Ocean County component, with a private pediatrics practice in Toms River; she was affiliated with Community Memorial Hospital.

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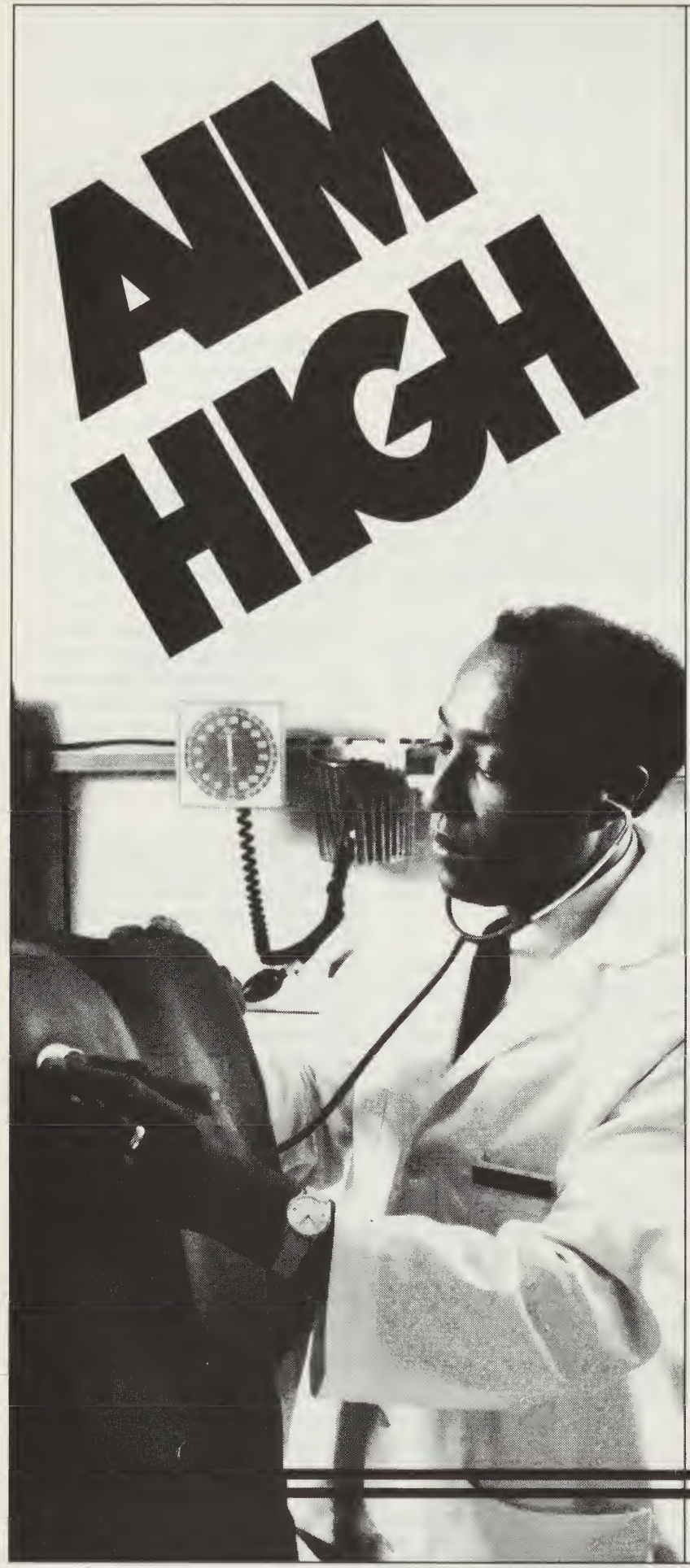
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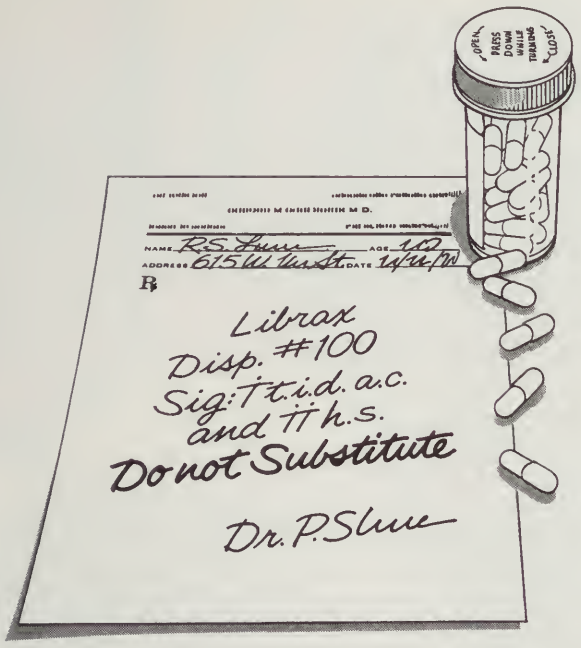
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* **Indications:** Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows: "Possibly" effective: as adjunctive therapy in the treatment of peptic ulcer and in the treatment of the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.
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Contraindications: Glaucoma; prostatic hypertrophy, benign bladder neck obstruction; hypersensitivity to chlordiazepoxide HCl and/or clidinium Br.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants, and against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving).

Usage in Pregnancy: **Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy. Advise patients to discuss therapy if they intend to or do become pregnant.**

As with all anticholinergics, inhibition of lactation may occur.

Withdrawal symptoms of the barbiturate type have occurred after discontinuation of benzodiazepines (see Drug Abuse and Dependence).

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship not established. Inform patients to consult physician before increasing dose or abruptly discontinuing this drug.

Adverse Reactions: No side effects or manifestations not seen with either compound alone reported with Librax. When chlordiazepoxide HCl is used alone, drowsiness, ataxia, confusion may occur, especially in elderly and debilitated; avoidable in most cases by proper dosage adjustment, but also occasionally observed at lower dosage ranges. Syncope reported in a few instances. Also encountered: isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent, generally controlled with dosage reduction; changes in EEG patterns may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice, hepatic dysfunction reported occasionally with chlordiazepoxide HCl, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax typical of anticholinergic agents, *i.e.*, dryness of mouth, blurring of vision, urinary hesitancy, constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.

Drug Abuse and Dependence: Withdrawal symptoms similar to those noted with barbiturates and alcohol have occurred following abrupt discontinuance of chlordiazepoxide; more severe seen after excessive doses over extended periods; milder after taking continuously at therapeutic levels for several months. After extended therapy, avoid abrupt discontinuation and taper dosage. Carefully supervise addiction-prone individuals because of predisposition to habituation and dependence.

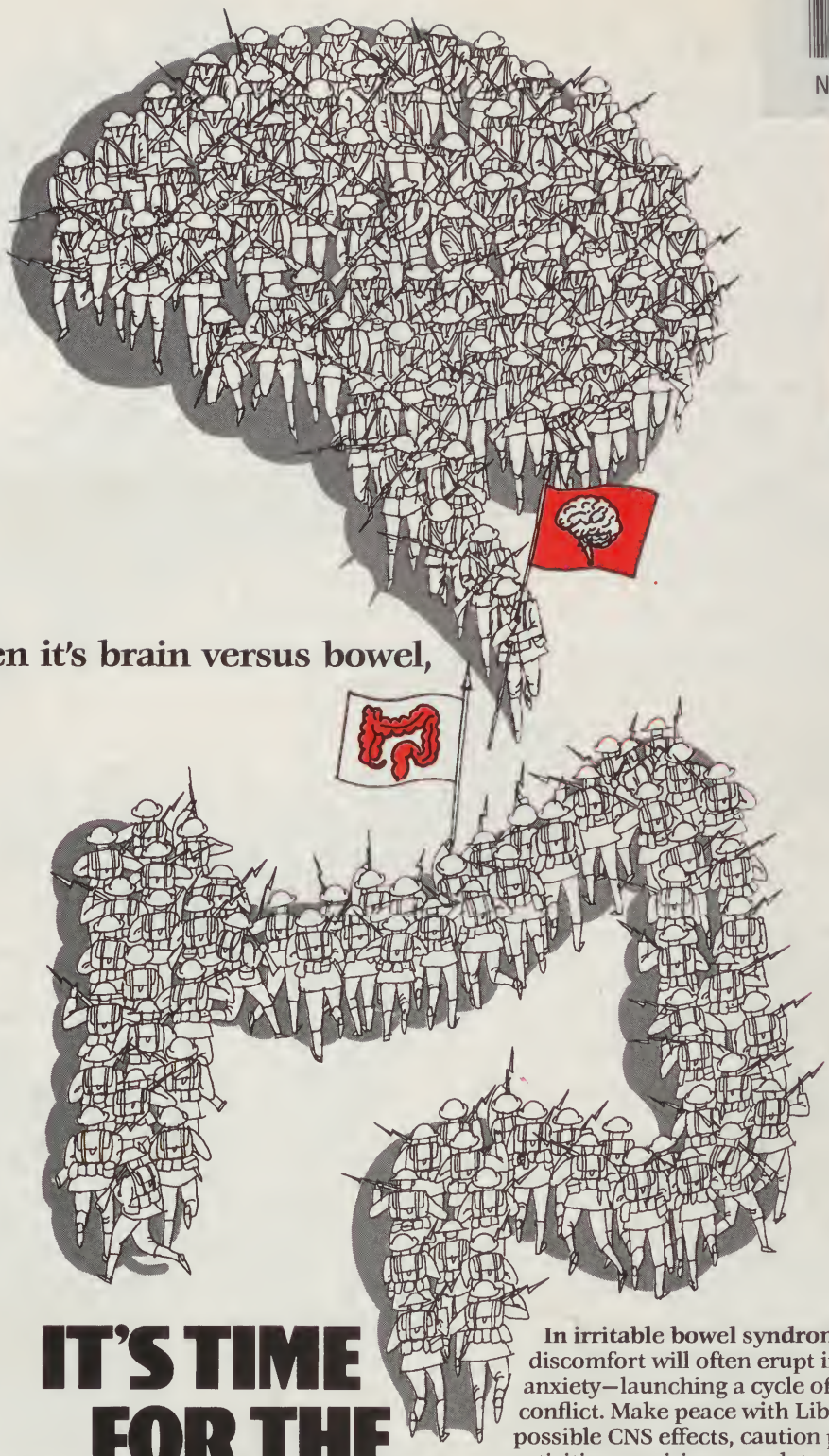
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THE JOURNAL OF THE MEDICAL SOCIETY OF NEW JERSEY

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NEWSWATCH

APPELLATE DIVISION APPROVES MALPRACTICE SURCHARGE

The Appellate Division of the Superior Court decided on February 13, 1991, that the surcharge imposed by the Insurance Commissioner to write off the $65 million Malpractice Reinsurance Association deficit was legal. Needless to say, MSNJ was disappointed, and along with the Medical Inter-Insurance Exchange of New Jersey (MIIENJ), is petitioning the Supreme Court to overrule the Appellate Division. At this point, however, the combined MSNJ-MIIENJ opposition has resulted in reducing the surcharge from 5 percent to 2.5 percent for all physicians except those actually insured by the Malpractice Reinsurance Association.

HCFA RELEASES IMPOUNDED FUNDS

In a reversal of its previous action, HCFA now has released $75 million of administrative expense to Part B carriers. Pennsylvania Blue Shield has announced to MSNJ that it does not anticipate any further delays on claims processing in the current fiscal year.

MANDATORY ASSIGNMENT HEATS UP

The issue of mandatory assignment is at the crisis point in the Legislature. All physicians are urged to contact their senators and assemblymen in opposition to mandatory Medicare assignment.

MEDICARE FOULS 1991 CHARGE DATA

HCFA finally released 1991 charges to physicians. Instead of MAACs, they now are called "limiting charges." There are many errors in the material. If your list is incomplete or inaccurate, you must contact Pennsylvania Blue Shield in writing and request corrective action.

SBME--BUSINESS PRACTICE RULES

The State Board of Medical Examiners (SBME) has proposed comprehensive regulations on the business aspect of medicine. A significant number of controversial issues are included. MSNJ offered comments in opposition to several sections and asked SBME to reconsider and to provide an opportunity for realistic input from physicians in private practice.

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What do breast cancer, hypertension, and HIV infection have in common?



Diagnosis and treatment before symptoms develop can make a difference in a patient's life.

There's more than one way to identify patients at risk of HIV infection.

But the two most important ways are by taking a sexual history and a drug history of all your male and female patients. Asking the right questions in a nonjudgmental way is critical.

A patient's medical history can also hold clues. A history of genital herpes, syphilis, or other STDs may be an indication of at-risk behavior.

You should be aware of lab indicators that signal the possibility of HIV infection: unexplained anemia, increased LDH or serum globulin count, low serum cholesterol count, or idiopathic thrombocytopenic purpura.

And probe for early clinical signs, including recent occurrences of oral thrush, weight loss, perianal herpes, zoster, chronic vaginitis, and hairy leukoplakia.

Once you suspect HIV infection, testing can make a difference.

Just as you would suggest mammography for patients at risk of breast cancer, suggest HIV testing once you've identified patients at risk of infection.

Because today, early, aggressive treatments can make a difference in the lives of patients who test positive.

Early treatment with RETROVIR helps keep asymptomatic patients symptom-free longer.

Now, treatments are available that can alter the course of HIV disease, especially when begun early–including treatment with RETROVIR.

RETROVIR Reduces the Rate of HIV Disease Progression by More Than Half[1]

	Placebo†	RETROVIR†
Progressions to AIDS*	33 6.6 rate‡	11 2.3 rate‡

*Patients were monitored for an average of one year.
†RETROVIR: n=453; placebo: n=428. Dosage was 500 mg/day.
‡Events per 100 person-years of observation.

In a recent study of asymptomatic patients (CD4 ≤ 500 cells/mm^3), RETROVIR reduced the rate of disease progression by more than half, at a dosage of 500 mg/day. Patients stayed symptom-free longer with RETROVIR.[1]

Although treatment of asymptomatic patients keeps them symptom-free longer and delays progression of disease, it is not known whether early treatment prolongs survival. RETROVIR has been studied in controlled trials in significant numbers of patients for limited periods of time. Therefore, the full safety and efficacy profile of RETROVIR has not yet been defined.



RETROVIR at 500 mg/day is well tolerated.

RETROVIR at the dose of 500 mg/day in symptomatic patients is generally well tolerated.[1] The occurrence of serious adverse events, compared with that initially reported with the higher doses of RETROVIR in advanced ARC/AIDS patients, has been greatly reduced.

So start probing early for HIV infection in your practice. Diagnosis and treatment can make a difference in your patients' lives.

Reference: 1. Volberding PA, Lagakos SW, Koch MA, et al. Zidovudine in asymptomatic human immunodeficiency virus infection: a controlled trial in persons with fewer than 500 CD4-positive cells per cubic millimeter. *N Engl J Med.* 1990;322:941-949.

Now more than ever–
test, monitor, and,
when appropriate, treat.

RETROVIR®
(zidovudine)

CAPSULES AND SYRUP

LIVING WITH HIV.

See following pages for brief summary of prescribing information.

RETROVIR® Capsules
RETROVIR® Syrup
(ZIDOVUDINE)

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BRIEF SUMMARY

WARNING: THERAPY WITH RETROVIR (ZIDOVUDINE) MAY BE ASSOCIATED WITH HEMATOLOGIC TOXICITY INCLUDING GRANULOCYTOPENIA AND SEVERE ANEMIA REQUIRING TRANSFUSIONS (SEE WARNINGS).

IN ADDITION, PATIENTS TREATED WITH ZIDOVUDINE MAY CONTINUE TO DEVELOP OPPORTUNISTIC INFECTIONS (OI'S) AND OTHER COMPLICATIONS OF HIV INFECTION AND, THEREFORE SHOULD BE UNDER CLOSE CLINICAL OBSERVATION.

Microbiology: ...The development of resistance to zidovudine has not been adequately studied and the frequency of zidovudine-resistant isolates existing in the general population is unknown. Reduced *in vitro* sensitivity to zidovudine has been observed, however, in viral isolates from some individuals who have received prolonged courses of zidovudine treatment. For the small number of patients from whom isolates were studied, no correlations were evident between the development of reduced sensitivity in the laboratory and clinical response. Therefore, the quantitative relationship between *in vitro* susceptibility of HIV to zidovudine and clinical response to therapy has not been established. Studies of the development of resistance to zidovudine are incomplete and the frequency and degree of changes in *in vitro* sensitivity of virus isolates from HIV infected patients with differing severity of immune compromise are unknown...

INDICATIONS AND USAGE: Retrovir is indicated for the management of adult patients with HIV infection who have evidence of impaired immunity (CD4 cell count of 500/mm³ or less) before therapy is begun. Retrovir is also indicated for HIV-infected children over 3 months of age who have HIV-related symptoms or who are asymptomatic with abnormal laboratory values indicating significant HIV-related immunosuppression.

These indications are based on the results of three randomized, double-blind, placebo-controlled trials of oral zidovudine in HIV-infected adult patients with CD4 cell counts of 500/mm³ or less, and two open-label studies involving 124 children ages 3.5 months to 12 years with advanced HIV-associated disease. Specifically, separate studies evaluated zidovudine therapy in asymptomatic HIV-infected adults, in adults with early symptomatic disease, in adults with advanced symptomatic HIV disease (AIDS or advanced ARC), and in children with advanced symptomatic HIV disease (pediatric AIDS or advanced ARC).

Adults Asymptomatic HIV Infection: A randomized, double-blind, placebo-controlled trial of oral zidovudine was conducted in asymptomatic, HIV-infected adults at 32 medical centers. Entry was dependent on the absence of signs and symptoms consistent with HIV disease, such as significant weight loss, fever, diarrhea, secondary infections and evidence of neurological dysfunction. In the study, 1338 asymptomatic individuals with absolute CD4 (T4) lymphocyte counts of less than 500 cells/mm³ received a regimen of either 100 mg zidovudine, 300 mg zidovudine, or placebo, each administered five times a day. These study participants were monitored for the development of signs and symptoms of HIV disease and tolerance to the study regimens. The study was terminated early because of a statistically significant difference in progression to advanced symptomatic HIV disease (AIDS or advanced ARC) between the 500 mg/day zidovudine group and the placebo group. Of the 1338 patients enrolled in the study, 38 of the 428 patients receiving placebo, 17 of the 453 individuals receiving 500 mg zidovudine, and 19 of the 457 recipients of 1500 mg zidovudine progressed to advanced symptomatic HIV disease when followed for a mean of 55 weeks (range 19-107 weeks). Of the progressions noted above, AIDS occurred in 33 placebo recipients, 11 individuals receiving 500 mg and 14 patients receiving 1500 mg zidovudine. Changes in immunologic and virologic parameters (ie, CD4[T4] lymphocyte count and serum p24 antigen levels) paralleled the observed clinical benefits. Consistent with various epidemiologic studies of individuals with HIV infection, patients in this study with lower CD_4 cell counts or P24 antigenemia were more likely to progress to AIDS. Virtually all patients (for whom data are available) experienced a decline in CD_4 cell counts to less than 200 per mm³ before developing an AIDS-defining opportunistic infection. Although treatment of asymptomatic patients delays progression of disease in those patients at risk of progression over the initial 1-2 years of treatment, it is not known whether early treatment prolongs survival.

Zidovudine was well tolerated in a majority of patients. The following adverse clinical events were reported at a significantly greater incidence in individuals receiving 500 mg/day of zidovudine versus placebo: headache, malaise, anorexia, nausea and vomiting (see ADVERSE REACTIONS).

The two most common laboratory abnormalities reported were anemia and granulocytopenia, each of which occurred more often in patients receiving higher doses. These toxicities were easily managed in most cases by temporary dose interruption.

Early Symptomatic HIV Disease: This randomized, double-blind, placebo-controlled trial of oral zidovudine, conducted at 29 medical centers, studied 713 adults with early manifestations of HIV disease (ie, a baseline CD4[T4] cell count of 200 to 800/mm³ and symptoms such as oral thrush, oral hairy leukoplakia or intermittent diarrhea). Patients received either placebo or 200 mg zidovudine every 4 hours (1200 mg/day). The trial was terminated early because of a statistically significant difference in the rates of development of advanced symptomatic HIV disease between the zidovudine and placebo groups. Of the 352 patients receiving placebo, 36 progressed to advanced symptomatic HIV disease, of whom 21 progressed to AIDS; whereas of the 361 zidovudine recipients, 13 progressed to advanced symptomatic HIV disease, of whom 5 progressed to AIDS.

Minimal toxicity was observed. Four percent of zidovudine recipients compared with none of the placebo recipients developed a hemoglobin concentration less than 8 g/dL and 4% of patients treated with zidovudine compared with 1% of placebo recipients developed a granulocyte count less than 750 cells/mm³. Asthenia, dyspepsia, nausea, and vomiting were the major adverse clinical events reported at significantly greater incidences in patients receiving zidovudine.

Advanced Symptomatic HIV Disease: This randomized, double-blind, placebo-controlled trial, conducted at 12 medical centers, was the original trial upon which the marketing of Retrovir was based. In this trial, 281 adults with advanced symptomatic HIV infection including AIDS were studied for a mean of four and a half months.

The patient population of this controlled trial consisted of 160 patients with AIDS (85 Retrovir and 75 placebo) who had recovered from their first episode of PCP diagnosed within the previous four months and 121 patients with ARC (59 Retrovir and 62 placebo) with multiple signs and symptoms of HIV infection, including mucocutaneous candidiasis and/or unexplained weight loss (≥ 15 lbs or >10% of prior body weight). All patients had evidence of impaired cellular immunity with an absence of delayed cutaneous hypersensitivity and CD4 (T4) lymphocytes less than 500 cells/mm³. All patients began therapy at a dose of 250 mg every 4 hours around the clock. This dosage was reduced or temporarily or permanently discontinued after serious marrow toxicity occurred. The trial was stopped early because of a statistically significant difference in mortality. There were 19 deaths in the placebo group and 1 in the Retrovir group. All deaths were apparently due to opportunistic infections (OI) or other complications of HIV infection. Treatment duration ranged from 12 weeks to 26 weeks, with a mean and median duration of 17 and 18 weeks, respectively.

Retrovir also significantly reduced the risk of acquiring an AIDS-defining OI in patients after 6 weeks of treatment. In addition, patients who received Retrovir generally did better than the placebo group in terms of several other measures of efficacy including performance level, neuropsychiatric function, maintenance of body weight and the number and severity of symptoms associated with HIV infection. A small, transient increase in mean CD4 (T4) counts was seen in the zidovudine group but the significance of this finding is unclear.

The most significant adverse reaction noted in the study was a depression of formed elements in the peripheral blood, which necessitated dose reduction or drug discontinuation in 34% of patients receiving Retrovir. Patients with lower CD4 counts were more likely to receive transfusions. 41% of Retrovir recipients and 16% of placebo recipients with <200 CD4 lymphocytes at entry were transfused (see ADVERSE REACTIONS). Only one of 30 Retrovir recipients and none of 30 placebo recipients with >200 CD4 lymphocytes required transfusion.

Although mean platelet counts in Retrovir recipients were statistically increased compared to mean baseline values, thrombocytopenia did occur in some patients. Twelve percent (12%) of Retrovir recipients compared to 5% of placebo recipients had >50% decreases from baseline platelet count.

At the conclusion of the placebo-controlled trial, approximately 80% of Retrovir and placebo recipients elected to enroll in an uncontrolled extension protocol in which all patients received Retrovir at a dose of 200 mg every four hours. This dose was chosen because of concern about hematologic toxicity and to allow for greater flexibility in dosing. These patients have been followed for variable periods of time. As the follow-up period lengthened, patient tracking became increasingly difficult. The intended treatment period of the original study was six months; however, some follow-up data are available for over 90% of patients originally enrolled in the trial. Data from patients in this and other studies show no new or unexpected clinical or laboratory adverse experiences for patients receiving Retrovir other than those listed (see ADVERSE REACTIONS), nor have previously reported adverse events increased significantly in frequency or severity with prolonged drug administration. At any time on study, approximately half of the patients received the recommended dose of zidovudine, while the remaining patients required reduction or interruption of their dosage regimen in response to myelosuppression and/or other clinical adverse events.

Benefits of therapy with Retrovir were observed during this extended period, although opportunistic infections continued to occur and additional patients died. Survival for all patients originally randomized to receive Retrovir was 96.5% at six months, 84.7% at one year, 68.3% at 18 months and 41.2% at two years. One year and two year survival for patients who entered the trial with AIDS was 79% and 31% when calculated since initiation of therapy (87% and 43%, respectively, since the first diagnosis of PCP). These survival rates were determined by the "intention to treat" method, which assumes all patients assigned to a drug actually took the drug throughout the study period.

While a direct comparison with survival data from other cohorts is not possible, untreated adult patients with AIDS diagnosed in San Francisco in 1985 who had survived 60 days after PCP had a one year survival of 34.7% and a two year survival of 4.2% from diagnosis of PCP. In a recent epidemiologic study of patients with AIDS diagnosed in San Francisco in 1986 and 1987, median survival was improved for patients receiving Retrovir compared to those not receiving therapy with Retrovir (21.6 vs 14.9 months). Actual survival of untreated patients is likely to be lower than reported because of the difficulty in complete ascertainment of mortality. Caution is advised in making comparisons from such "natural history" experience since case definitions and follow-up practices vary.

Other, uncontrolled studies have shown that Retrovir may be of benefit in treating women, intravenous drug users, and racial minorities, in addition to the patient population (primarily white males) included in the controlled trials.

Dose Comparison Study: Results from a randomized, unblinded, dose comparison study of zidovudine, in adults with AIDS who had experienced an episode of PCP, indicate that an induction dose of zidovudine 200 mg administered orally every four hours (1200 mg/day) for one month, followed by chronic administration of 100 mg every 4 hours (600 mg/day), was associated with survival rates and frequency of opportunistic infections comparable to those observed in patients administered higher dosages as tolerated. The 600 mg per day regimen was also associated with a lower incidence of hematologic toxicity. The effectiveness of this lower dose in improving the neurologic dysfunction associated with HIV disease, however, is unknown (see DOSAGE AND ADMINISTRATION).

Pediatric Symptomatic HIV Disease: Two open-label studies have evaluated the pharmacokinetics, safety and efficacy of Retrovir in 124 children with advanced HIV disease (84 AIDS and 40 with other clinical and laboratory evidence of advanced HIV disease). The median age at entry was 3.3 years with 14% less than 12 months of age. In the majority of cases (73%), HIV was acquired by vertical transmission from an HIV-infected mother.

Thirty-six children were enrolled in the Phase 1 study, which evaluated three intravenous dosing regimens administered for 4 to 8 weeks. All children subsequently switched to an oral dose of 180 mg/m² every 6 hours and were followed for a mean of 465 days (range 121 to 855 days). Eighty-eight children participated in the Phase 2 study and these children were monitored for a mean of 186 days (range 3 to 352 days). In the Phase 2 study, oral zidovudine was initiated at a dose of 180 mg/m² every 6 hours.

Clinical, immunologic and virologic improvements were observed among some of the children receiving zidovudine in these open-label studies. Clinical improvements included reductions in hepatosplenomegaly and increases in weight percentiles in previously growth retarded children. The probability of remaining free of opportunistic infections through 12 months of follow-up was 0.76. Thirty-seven children developed one or more documented serious bacterial infections while participating in the studies. Seven of these children had more than one documented serious bacterial infection. The probability of survival at 12 months is 0.87 for the 124 patients enrolled in the Phase 1 and Phase 2 studies.

Improvements in the immunologic parameters CD4 cell counts and immunoglobulin concentration were observed among the study participants. For children with severely depressed CD4 cell counts (<500/mm³) at entry, a mean increase of 148/mm³ in CD4⁺ lymphocyte cell count was observed during the first two months of zidovudine therapy. Thereafter, CD4 cell counts declined but remained above baseline through 9 months of follow-up. A tendency towards normalization of elevated immunoglobulin concentrations (primarily IgG) was observed among study participants.

Substantial reductions in serum and CSF P_{24} antigen concentrations were observed in some patients, as well as a reduction in the number of patients with positive CSF HIV cultures, providing evidence of anti-retroviral effect.

The most frequently reported adverse events were anemia (Hgb < 7.5 g/dL) and neutropenia (< 750/mm³), which occurred in forty-six percent of the children. Thirty-six percent of the patients had their dose modified due to the development of hematologic abnormalities and 30% received transfusions for anemia. Four patients had dosing permanently discontinued due to neutropenia (see ADVERSE REACTIONS).

CONTRAINDICATIONS: Retrovir Capsules and Syrup are contraindicated for patients who have potentially life-threatening allergic reactions to any of the components of the formulations.

WARNINGS: Zidovudine has been studied in controlled trials in significant numbers of asymptomatic and symptomatic HIV infected patients, but only for limited periods of time. Therefore, the full safety and efficacy profile of zidovudine has not been defined, particularly in regard to prolonged use and especially in HIV infected individuals who have less advanced disease (see following sections for more specific information: INDICATIONS AND USAGE, Microbiology, Carcinogenesis, Mutagenesis, Impairment of Fertility).

Insufficient clinical experience exists to recommend a dosing regimen in infants under 3 months of age. Preliminary evidence indicates that zidovudine clearance may be reduced in children less than one month of age.

A positive test for HIV-antibody in children under 15 months of age may represent passively acquired maternal antibodies, rather than an active antibody response to infection in the infant. Thus, the presence of HIV antibody in a child less than 15 months of age must be interpreted with caution, especially in the asymptomatic infant. Confirmatory tests such as serum P_{24} antigen or viral culture should be pursued in such children.

Zidovudine should be used with extreme caution in patients who have bone marrow compromise evidenced by granulocyte count <1000/mm³ or hemoglobin <9.5 g/dL. In all of the placebo-controlled studies, but most frequently in patients with advanced symptomatic HIV disease, anemia and granulocytopenia were the most significant adverse events observed (see ADVERSE REACTIONS). There have been reports of pancytopenia associated with the use of zidovudine, which was reversible in most instances after discontinuance of the drug.

Significant anemia most commonly occurred after 4 to 6 weeks of therapy and in many cases required dose adjustment, discontinuation of zidovudine, and/or blood transfusions. Frequent blood counts are strongly recommended in patients with advanced HIV disease taking zidovudine. For asymptomatic HIV-infected individuals and patients with early HIV disease, most of whom have better marrow reserve, blood counts may be obtained less frequently, depending upon the patient's overall status. If anemia or granulocytopenia develops, dosage adjustments may be necessary (see DOSAGE AND ADMINISTRATION in full prescribing information).

Sensitization reactions, including anaphylaxis in one patient, have been reported in individuals receiving zidovudine therapy. Patients experiencing a rash should undergo medical evaluation.

Coadministration of zidovudine with other drugs metabolized by glucuronidation should be avoided because the toxicity of either drug may be potentiated (see Drug Interactions under PRECAUTIONS). Zidovudine recipients who used acetaminophen during the controlled trial in advanced HIV disease, had an increased incidence of granulocytopenia which appeared to be correlated with the duration of acetaminophen use.

PRECAUTIONS:

General: Zidovudine is eliminated from the body primarily by renal excretion following metabolism in the liver (glucuronidation). There are currently very little data available concerning the use of zidovudine in patients with impaired renal function (see Pharmacokinetics subsection of CLINICAL PHARMACOLOGY) and no data in patients with impaired hepatic function. These patients may be at greater risk of toxicity from zidovudine.

Information for Patients: See full prescribing information.

Drug Interactions: The interaction of other drugs with zidovudine has not been studied in a systematic manner. Coadministration of zidovudine with drugs that are nephrotoxic, cytotoxic, or which interfere with RBC/WBC number or function (eg, dapsone, pentamidine, amphotericin B, flucytosine, vincristine, vinblastine, adriamycin, or interferon) may increase the risk of toxicity. Limited data suggest that probenecid may inhibit glucuronidation and/or reduce renal excretion of zidovudine. In addition, other drugs (eg, acetaminophen, aspirin, or indomethacin) may competitively inhibit glucuronidation (see WARNINGS). Phenytoin levels have been reported to be low in some patients receiving zidovudine, while in one case a high level was documented. These observations suggest that phenytoin levels should be carefully monitored in patients receiving zidovudine since many patients with advanced HIV infections have CNS conditions which may predispose to seizure activity.

Some experimental nucleoside analogues which are being evaluated in HIV-infected patients may affect RBC/WBC number or function and may increase the potential for hematologic toxicity of zidovudine. Some experimental nucleoside analogues affecting DNA replication antagonize the *in vitro* antiviral activity of zidovudine against HIV and thus, concomitant use of such drugs should be avoided.

Some drugs such as trimethoprim-sulfamethoxazole, pyrimethamine, and acyclovir may be necessary for the management or prevention of opportunistic infections. In the controlled trial, in patients with advanced HIV disease, increased toxicity was not detected with limited exposure to these drugs. However, there is one published report of neurotoxicity (protound lethargy) associated with concomitant use of zidovudine and acyclovir.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Zidovudine was administered orally at three dosage levels to separate groups of mice and rats (60 females and 60 males in each group). Initial single daily doses were 30, 60 and 120 mg/kg/day in mice and 80, 220 and 600 mg/kg/day in rats. The doses in mice were reduced to 20, 30 and 40 mg/kg/day after day 90 because of treatment-related anemia, whereas in rats only the high dose was reduced to 450 mg/kg/day on day 91 and then to 300 mg/kg/day on day 279.

In mice, seven late-appearing (after 19 months) vaginal neoplasms (5 non-metastasizing squamous cell carcinomas, one squamous cell papilloma and one squamous polyp) occurred in animals given the highest dose. One late-appearing squamous cell papilloma occurred in the vagina of a middle dose animal. No vaginal tumors were found at the lowest dose.

In rats, two late-appearing (after 20 months), non-metastasizing vaginal squamous cell carcinomas occurred in animals given the highest dose. No vaginal tumors occurred at the low or middle dose in rats.

No other drug-related tumors were observed in either sex of either species.

It is not known how predictive the results of rodent carcinogenicity studies may be for man. At doses that produced tumors in mice and rats, the estimated drug exposure (as measured by AUC) was approximately 3 times (mouse) and 24 times (rat) the estimated human exposure at the recommended therapeutic dose of 100 mg every 4 hours.

No evidence of mutagenicity (with or without metabolic activation) was observed in the Ames *Salmonella* mutagenicity assay. In a mutagenicity assay conducted in L5178Y/TK$^{+/-}$ mouse lymphoma cells, zidovudine

was weakly mutagenic in the absence of metabolic activation only at the highest concentrations tested (4000 and 5000 μg/mL). In the presence of metabolic activation, the drug was weakly mutagenic at concentrations of 1000 μg/mL and higher. In an *in vitro* mammalian cell transformation assay, zidovudine was positive at concentrations of 0.5 μg/mL and higher. In an *in vitro* cytogenetic study performed in cultured human lymphocytes, zidovudine induced dose-related structural chromosomal abnormalities at concentrations of 3 μg/mL and higher. No such effects were noted at the two lowest concentrations tested, 0.3 and 1 μg/mL. In an *in vivo* cytogenetic study in rats given a single intravenous injection of zidovudine at doses of 37.5 to 300 mg/kg, there were no treatment-related structural or numerical chromosomal alterations in spite of plasma levels that were as high as 453 μg/mL five minutes after dosing.

In two *in vivo* micronucleus studies (designed to measure chromosome breakage or mitotic spindle apparatus damage) in male mice, oral doses of zidovudine of 100 to 1000 mg/kg/day administered once daily for approximately 4 weeks induced dose-related increases in micronucleated erythrocytes. Similar results were also seen after 4 or 7 days of dosing at 500 mg/kg/day in rats and mice.

No effect on male or female fertility (judged by conception rates) was seen in rats given zidovudine orally at doses up to 450 mg/kg/day.

Pregnancy: Pregnancy Category C. Oral teratology studies in the rat and in the rabbit at doses up to 500 mg/kg/day revealed no evidence of teratogenicity with zidovudine. The incidence of fetal resorptions was increased in rats given 150 or 450 mg/kg/day and rabbits given 500 mg/kg/day. The doses used in the teratology studies resulted in peak plasma concentrations in rats of 68 to 234 times the peak human plasma concentrations and in rabbits of 14 to 90 times the peak human plasma concentrations. It is not known whether zidovudine can cause fetal harm when administered to a pregnant woman or can affect reproductive capacity. Zidovudine should be given to a pregnant woman only if clearly needed.

Nursing Mothers: It is not known whether zidovudine is excreted in human milk. Because many drugs are excreted in human milk and because of the potential for serious adverse reactions from zidovudine in nursing infants, mothers should be instructed to discontinue nursing if they are receiving zidovudine.

Pediatric Use: See INDICATIONS and WARNINGS sections.

ADVERSE REACTIONS: Adults: The frequency and severity of adverse events associated with the use of zidovudine in adults are greater in patients with more advanced infection at the time of initiation of therapy. The following tables summarize the relative incidence of hematologic adverse events observed in the placebo-controlled clinical studies by severity of HIV disease present at the start of treatment:

Asymptomatic HIV Infection Study (n=1338)	Granulocytopenia (<750/mm³)		
	Zidovudine		Placebo
	1500 mg*	500 mg	
CD4 ≤ 500	6.4% (n=457)	1.8% (n=453)	1.6% (n=428)
Asymptomatic HIV Infection Study (n=1338)	**Anemia (Hgb<8 g/dL)**		
	Zidovudine		Placebo
	1500 mg*	500 mg	
CD4 ≤ 500	6.4% (n=457)	1.1% (n=453)	0.2% (n=428)

Early Symptomatic HIV Disease Study (n=713)	Granulocytopenia (<750/mm³)		Anemia (Hgb<8 g/dL)	
	Zidovudine 1200 mg	Placebo	Zidovudine 1200 mg	Placebo
CD4>200	4% (n=361)	1% (n=352)	4% (n=361)	0% (n=352)

Advanced Symptomatic HIV Disease Study (n=281)	Granulocytopenia (<750/mm³)		Anemia (Hgb<7.5 g/dL)	
	Zidovudine 1500 mg*	Placebo	Zidovudine 1500 mg*	Placebo
CD4>200	10% (n=30)	3% (n=30)	3% (n=30)	0% (n=30)
CD4<200	47% (n=114)	10% (n=107)	29% (n=114)	5% (n=107)

*Three times the currently recommended dose in asymptomatic patients.

The anemia reported in patients receiving zidovudine appeared to be the result of impaired erythrocyte maturation as evidenced by increased macrocytosis (MCV) while on drug.

The HIV-infected adults participating in these clinical trials often had baseline symptoms and signs of HIV disease and/or experienced adverse events at some time during study. It was often difficult to distinguish adverse events possibly associated with zidovudine administration from underlying signs of HIV disease or intercurrent illnesses. The following table summarizes clinical adverse events or symptoms which occurred in at least 5% of all patients with advanced HIV disease treated with zidovudine in the original placebo-controlled study. Of the items listed in the table, only severe headache, nausea, insomnia and myalgia were reported at a significantly greater rate in zidovudine recipients.

Percentage (%) of Patients with Clinical Events in the Advanced HIV Disease Study		
Adverse Event	Zidovudine (n=144) %	Placebo (n=137) %
BODY AS A WHOLE		
Asthenia	19	18
Diaphoresis	5	4
Fever	16	12
Headache	42	37
Malaise	8	7
GASTROINTESTINAL		
Anorexia	11	8
Diarrhea	12	18
Dyspepsia	5	4
GI Pain	20	19
Nausea	46	18
Vomiting	6	3
MUSCULOSKELETAL		
Myalgia	8	2
NERVOUS		
Dizziness	6	4
Insomnia	5	1
Paresthesia	6	3
Somnolence	8	9
RESPIRATORY		
Dyspnea	5	3
SKIN		
Rash	17	15
SPECIAL SENSES		
Taste Perversion	5	8

Clinical adverse events which occurred in less than 5% of all adult patients treated with zidovudine in the advanced HIV study are listed below. Since many of these adverse events were seen in placebo-treated patients as well as zidovudine recipients, their possible relationship to the drug is unknown.

Body as a whole: body odor, chills, edema of the lip, flu syndrome, hyperalgesia, back pain, chest pain, lymphadenopathy.
Cardiovascular: vasodilation.
Gastrointestinal: constipation, dysphagia, edema of the tongue, eructation, flatulence, bleeding gums, rectal hemorrhage, mouth ulcer.
Musculoskeletal: arthralgia, muscle spasm, tremor, twitch.
Nervous: anxiety, confusion, depression, emotional lability, nervousness, syncope, loss of mental acuity, vertigo.
Respiratory: cough, epistaxis, pharyngitis, rhinitis, sinusitis, hoarseness.
Skin: acne, pruritus, urticaria.
Special senses: amblyopia, hearing loss, photophobia.
Urogenital: dysuria, polyuria, urinary frequency, urinary hesitancy.

Subsequent to the initial trial, myopathy and sensitization reactions, including anaphylaxis in one patient, have been reported in adults receiving zidovudine therapy.

All unexpected events and expected events of a severe or life-threatening nature were monitored for adults in the placebo-controlled studies in early HIV disease and asymptomatic HIV infection. Data concerning the occurrence of additional signs or symptoms were also collected. No distinction was made in reporting events between those possibly associated with the administration of the study medication and those due to the underlying disease. The following tables summarize all those events reported at a statistically significant greater incidence for zidovudine recipients in these studies:

Percentage (%) of Patients with Clinical Events in the Early Symptomatic HIV Disease Study		
Adverse Event	Zidovudine (n=361) %	Placebo (n=352) %
BODY AS A WHOLE		
Asthenia	69	62
GASTROINTESTINAL		
Dyspepsia	6	1
Nausea	61	41
Vomiting	25	13

Percentage (%) of Patients with Clinical Events* in an Asymptomatic HIV Infection Study			
Adverse Event	1500 mg Zidovudine*** (n=457) %	500 mg Zidovudine (n=453) %	Placebo (n=428) %
BODY AS A WHOLE			
Asthenia	10.1	8.6**	5.8
Headache	58.0**	62.5	52.6
Malaise	55.6	53.2	44.9
GASTROINTESTINAL			
Anorexia	19.3	20.1	10.5
Constipation	8.1	6.4**	3.5
Nausea	57.3	51.4	29.9
Vomiting	16.4	17.2	9.8
NERVOUS			
Dizziness	20.8	17.9**	15.2

*Reported in ≥ 5% of study population.
**Not statistically significant versus placebo.
***Three times the currently recommended dose in asymptomatic patients.

The following events have been reported in adult patients treated with zidovudine: seizures, nail pigmentation, changes in liver function tests. They may also occur as part of the underlying disease process. As such, the relationship between these events and the use of zidovudine is uncertain.

Pediatrics: The incidences of anemia and granulocytopenia among children with advanced HIV disease receiving zidovudine were similar to the incidences which have been reported for adults with AIDS or advanced ARC (see above). Management of neutropenia and anemia included, in some cases, dose modification and/or blood product transfusions. In the open-label studies, seventeen percent had their dose modified (generally a reduction in dose by 30%) due to anemia and 25% had their dose modified (temporary discontinuation or dose reduction by 30%) for neutropenia. Four children had zidovudine permanently discontinued for neutropenia. The following table summarizes the occurrence of anemia (Hgb < 7.5 g/dL) and granulocytopenia (<750/mm³) among 124 children receiving zidovudine for a mean of 267 days (range 3 to 855 days):

Advanced Pediatric HIV disease (N=124)	Granulocytopenia (< 750/mm³)		Anemia (Hgb < 7.5 g/dL)	
	N	%	N	%
	48	39	28*	23

*Twenty-two children received one or more transfusions due to a decline in hemoglobin to < 7.5 g/dL; an additional 15 children were transfused for hemoglobin levels > 7.5 g/dL. Fifty-nine percent of the patients transfused had a pre-study history of anemia or transfusion requirement.

An increase in MCV (macrocytosis) was observed among the majority of children enrolled in the studies.

In the open-label studies involving 124 children, 16 clinical adverse events were reported by 24 children. No event was reported by more than 5.6% of the study populations. Due to the open-label design of the studies, it was difficult to determine possible zidovudine-related versus disease-related events. Therefore, all clinical events reported as associated with zidovudine therapy or of unknown relationship to zidovudine therapy are presented in the following table:

Percentage (%) of Pediatric Patients with Clinical Events in Open Label Studies		
Adverse Event	N	%
BODY AS A WHOLE		
Fever	4	3.2
Phlebitis*/Bacteremia	2	1.6
Headache	2	1.6
GASTROINTESTINAL		
Nausea	1	0.8
Vomiting	6	4.8
Abdominal Pain	4	3.2
Diarrhea	1	0.8
Weight Loss	1	0.8
NERVOUS		
Insomnia	3	2.4
Nervousness/Irritability	2	1.6
Decreased Reflexes	7	5.6
Seizure	1	0.8
CARDIOVASCULAR		
Left Ventricular Dilation	1	0.8
Cardiomyopathy	1	0.8
S_3 Gallop	1	0.8
Congestive Heart Failure	1	0.8
Generalized Edema	1	0.8
ECG Abnormality	3	2.4
UROGENITAL		
Hematuria/Viral Cystitis	1	0.8

*Peripheral vein I.V. catheter site

The clinical adverse events reported among adult zidovudine recipients may also occur in children.

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AIR FORCE

MSNJ NEWSLETTER

PEDIATRIC HEMATOLOGY-ONCOLOGY

The first statewide pediatric hematology-oncology conference will be held on April 26, 1991; the program is sponsored by the six Valerie Fund Children's Centers in New Jersey (Children's Hospital of New Jersey; Cooper Hospital/University Medical Center; Monmouth Medical Center; Newark Beth Israel Medical Center; Overlook Hospital; and Robert Wood Johnson University Hospital). The program will be an overview of childhood cancer and blood diseases; in future years, symposiums will focus on more specific topics. For registration information, please contact the Academy of Medicine of New Jersey at 609/896-1717.

CLIA-88 AND POL REGULATION UPDATE

The Centers for Disease Control (CDC) has told the Health Care Financing Administration (HCFA) that it would need two years to review the 50,000 CLIA-88 comments and develop a new format. HCFA is concerned with this lengthy timetable for revisions and is seriously considering proposing it again for comment rather than making the next version final. HCFA chief, Gail Wilensky, PhD, has stated that a final rule of CLIA-88 should be expected by summer 1991. HCFA has pledged that the final rule of CLIA-88 will be much improved.

New Jersey physicians with private office laboratories (POLs) should be aware that the state of New Jersey will publish its own set of regulations for POLs.

The New Jersey State Department of Environmental Protection has begun inspecting physician offices. Physicians need to comply with hazardous waste laws and information on waste disposal should be well organized and properly documented.

INTERNATIONAL MEDICAL GRADUATES (IMGs)

The AMA has adopted a position in support of a federal bill that has the potential to help improve the environment for IMGs in the area of licensure, licensure by endorsement, applications for medical staff positions, and requests for clinical privileges. In addition, the AMA opposed the inclusion of what we believe to be discriminatory language against IMGs in the Medicaid program. While tense actions will not solve all of the problems, they represent an attempt by the AMA to move to a more proactive role in assisting the IMG community to overcome problems encountered in the practice of medicine in this country.

The AMA Board of Trustees voted to support with modifications H.R. 5452, "Facilitation in Licensing for IMGs Act," introduced into Congress in September 1990. This position was adopted in accordance with recommendations made by the AMA Advisory Committee on IMGs as well as the AMA's Council on Legislation. The bill seeks to provide two measures to help in overcoming what IMGs view as the discriminatory practices they face in obtaining initial licensure, licensure by endorsement, medical staff positions, and clinical privileges. In its original form, the bill would create a voluntary national repository of IMG records, to be established by the Secretary of the Department of Health and Human Services (DHHS) after consultation with the Federation of State Medical Boards (FSMB), the Educational Commission for Foreign Medical

Graduates (ECFMG), and a prominent group representing IMGs. Second, the bill would establish an annual $100,000 grant to be made available to the FSMB to assist in the development and administration of a uniform medical licensing examination.

NEW DEPUTY COMMISSIONER OF HEALTH NAMED

Gerry Goodrich has been named as the Deputy Commissioner of Health, overseeing health planning and reimbursement. Mr. Goodrich was formerly an official of the New York Health and Hospitals Corporation. He has a law degree from Boston University and a master's degree in public health from the Harvard School of Public Health.

AMA OPPOSES MULTIPLE COPY Rx

The AMA opposes federal intrusion into the doctor-patient relationship. They took issue with and helped to defeat Representative Pete Stark's legislation requiring all states to enact multiple copy prescriptions for controlled substances to receive full federal Medicaid funds. This law would have monitored prescriptions for all patients, not just those receiving Medicaid. The AMA believes its PADS program is the answer. The Prescription Abuse Data Synthesis is a comprehensive data-gathering system helping to identify fraudulent prescriptions and overprescribing in your community—while remaining confidential.

CONFERENCE ON DEVELOPMENTAL DISABILITIES

The Academy of Medicine of New Jersey and Mainstreaming Medical Care, a project of the Association for Retarded Citizens (ARC) of New Jersey, are cosponsoring a one-day conference to educate health care professionals on medical care for people with developmental disabilities. The conference will be held on Thursday, May 16, 1991, from 9:15 A.M. to 3:30 P.M. at the Cook Campus Center of Rutgers University, New Brunswick. Increasingly, people with mental retardation and other developmental disabilities are living in community residences and seeking medical and dental care from local physicians and dentists; yet, most physicians have not been educated on the issues that may arise in treating this special population.

The Academy of Medicine of New Jersey designates this continuing medical education activity for 4 credit hours in category I of the Physician's Recognition Award of the American Medical Association. This program also has been approved for four CME credit hours through the American Association of Family Physicians (AAFP).

The preregistration deadline is May 1, 1991. Due to space limitations, early preregistration is suggested. For more information or to request a brochure, please call Beverly Roberts, Project Director, Mainstreaming Medical Care, 908/246-2525.

NO-FAULT MEDICAL FEE SCHEDULE

Many members have called the Medical Society of New Jersey about the PIP fee schedule. This is the latest information available:

- The Department of Insurance in Trenton had until January 15, 1991, to receive comments concerning the proposed medical fee schedule. Therefore, there may not be a definitive fee schedule for some time. Nonetheless, the auto insurance reform legislation requires the fee schedule be in effect as of January 1, 1991; thus, the schedule released in December 1990 is applicable for services rendered in 1991.
- You should continue to bill at your regular fee level. You may not, however, balance-bill a patient beyond the schedule.
- Do not bill based on the fee schedule. Remember, these fees are to be reviewed periodically. You should, therefore, continue billing at your usual and customary rate, but you may not balance-bill for any procedure on the schedule.

- A copy of the schedule is useful to determine whether or not the carrier has paid correctly and whether the procedure is covered on the schedule. If a procedure is not on the schedule, you may expect to receive your regular fee. If you do not, you can either request arbitration or balance-bill the patient.
- The Medical Society of New Jersey has requested the court to order the insurance department to provide the schedule to all physicians upon written request. In the interim, the schedule in its present form is available to MSNJ members at no cost upon written request.

MEETING OF THE PENNSYLVANIA BLUE SHIELD PHYSICIANS LIAISON COMMITTEE

At the first meeting of the Pennsylvania Blue Shield (PBS) Physicians Liaison Group, the Medical Society of New Jersey was represented by R. Gregory Sachs, MD, Richard Sharrett, MD, Louis Keeler, MD, and Ian Samson, MD.

PBS is unique being a Blue Shield only program, and the largest Medicare Part B carrier in the country. Interestingly, 92 percent of payments in the first quarter went to participating doctors. Fifteen of the 31 members of the board of directors are physicians. PBS emphasized the role that physicians play in their corporate thinking. Further, it was explained that PBS does not benefit financially from payment decisions made under the Medicare program and that they are reimbursed on a per unit basis, regardless of the payment decision. This, nevertheless, represents a substantial sum as the organization produces $3 billion in revenue and processes over 57 million claims. Payment to PBS by the federal government is a little over $1.00 per claim. Mr. Bryant noted that the carrier has independent control over many activities. Because of this, he felt the carrier could become more responsive and more accurate. He recognized, however, that there are issues that can only be changed by HCFA and activities that cannot be changed because they are of a statutory nature. However, he stressed that PBS intended to listen to the Liaison Group, and to be sensitive to all suggestions.

A point of the issue was the participating status of professional consultants. Dr. Ricci outlined PBS's attitude as to why most consultants are participating physicians. This certainly was regarded as a controversial aspect of the system and the Liaison Group expressed concern. The Liaison Committee, in a broad sense, disagreed with this policy.

The issue of participating physicians being given preeminence in PBS committees was raised again. Initially, Blue Shield requested only participating physicians to be appointed to the Liaison Group. However, in response to objections from the representative state medical societies, wider latitude was given to the societies and, in fact, 60 percent of the members in the group are nonparticipating. The question of the "hassle factor" was discussed at length. Mr. Ross suggested that PBS would try to eliminate "buck passing" and improve communication in dealing with problems.

A question of an inhumane method of claim denials was raised. It was suggested to PBS that where there is a blanket review or investigation, that PBS refer the matter to the Liaison Committee for help in insuring that it be handled in a fair and just manner. The issue of confusion as to the ultimate responsibility for decisions being either HCFA decisions or PBS decisions was raised. Response from PBS was that they intervene on a number of issues and inform HCFA where appropriate. This was particularly true where second opinions were identified as not cost effective. They have communicated to the government along these lines. The Liaison Committee expressed a desire to communicate more closely with PBS in support of issues where PBS has the ability to affect change by HCFA. It was felt to be important to relay this knowledge to providers for their information, as well as to elicit support for PBS.

The Medicare Physicians Liaison Group does not replace the Medical Advisory Committee to PBS. However, it is hoped that input from providers will materially affect the manner in which PBS does business with providers. □ Ian D. Samson, MD

MEDICAL SOCIETY OF NEW JERSEY

COUNTY AND SPECIALTY SOCIETY, ACADEMY OF MEDICINE OF NEW JERSEY, MSNJ AUXILIARY, AND AMA DELEGATION ATTENDANCE AT MEETINGS OF THE BOARD OF TRUSTEES

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RBRVS SET FOR PROCEDURES UNDER PHYSICIAN PAY PLAN

HCFA has issued a draft report on the Medicare physician fee schedule that contains relative values for 2,700 procedures that account for approximately 95 percent of the charges allowed under Medicare. To date, 33 medical and surgical specialties have been examined, covering dermatology, psychiatry, pathology and ophthalmology. According to RVS developer and Harvard University economist William Hsiao, the Resource Based Relative Value Scale (RBRVS) methodology appears to apply to all 33 specialties reviewed to date and that costs can be "nationally and systematically" assigned. Hsiao has commented that the intensity of service varies among physicians and that time measurement to perform a service is an incomplete measure for payments to be based upon. According to Hsiao, older patients require no more physician time than younger patients. The final fee schedule is expected to take effect in January 1992.

SPECIALIST'S INCOME INCREASE

According to the American Medical Association, in the late 1980s, the overall rate of increase in physician's income had declined. Physicians' average net incomes increased only 7.7 percent in 1989 compared with 9.4 percent in 1988. Adjusted for inflation, the 1989 increase was only 2 percent. However, during 1988-1989, certain specialists, mainly radiologists and pathologists, experienced a substantial increase in their incomes. The average net income for pathologists increased by 17.9 percent, from $131,000 to $154,000 and the average net income for radiologists increased by approximately 12 percent from $184,600 to $210,500. Dr. Charles Tupper, president of the AMA, attributes the rise in radiologist's net income to the fact that physicians no longer are paying off the expensive imaging equipment that they acquired in the early 1980s. Tupper had no explanation for the increase in pathologists' income.

HHS SAYS LIMIT PHYSICIAN LIABILITY

A study done for the Agency for Health Care Policy & Research of the Department of Health and Human Services states that the most effective way of cutting malpractice insurance premiums was to limit physician liability. When evaluating the effect on general surgeons, the study projected first-year savings of 13 percent and long-term savings of 67 percent. Other approaches that would lower costs include reducing the statute of limitations by one year and requiring pretrial screening.

THE AHA SEARCH

A seven-member search committee, led by AHA Chairman-Elect Thomas Smith, CEO of Yale-New Haven Hospital, will begin the process of selecting a replacement for Carol McCarthy who will be leaving as AHA's president. Two major issues being suggested for the agenda are whether to hire an outside headhunter and whether to seek an "outside the industry" big name.

AMA SCRUTINIZES PHYSICIAN PROFILING

Addressing concerns that physician profiling will be punitive and intrusive, the AMA is scrutinizing HCFA's profiling criteria and carrier instructions. Medicare carriers are building profile patterns of physician practices by area and specialty. Those profiles will provide data about physicians whose utilization patterns differ substantially from their colleagues. Physicians exceeding "normal" practice patterns will receive an "educational" letter suggesting meeting with the carrier staff to discuss the profile differences. HCFA estimates that only about 1 percent of physicians will receive profile letters.

FINI

"If you could kick the person responsible for most of your trouble, you would not be able to sit down for two weeks."

One Of A Kind



Zantac®

ranitidine HCl/Glaxo 150 mg and 300 mg tablets

Please see Brief Summary of Prescribing Information on adjacent page.

Glaxo/ ROCHE



One Of A Kind

Zantac®

ranitidine HCl/Glaxo 150 mg and 300 mg tablets

Zantac® 150 Tablets **BRIEF SUMMARY**
(ranitidine hydrochloride)

Zantac® 300 Tablets
(ranitidine hydrochloride)

Zantac® Syrup
(ranitidine hydrochloride)

The following is a brief summary only. Before prescribing, see complete prescribing information in Zantac® product labeling.

INDICATIONS AND USAGE: Zantac® is indicated in:
1. Short-term treatment of **active duodenal ulcer**. Most patients heal within four weeks.
2. **Maintenance therapy** for duodenal ulcer patients at reduced dosage after healing of acute ulcers.
3. The treatment of **pathological hypersecretory conditions** (eg, Zollinger-Ellison syndrome and systemic mastocytosis).
4. Short-term treatment of **active, benign gastric ulcer**. Most patients heal within six weeks and the usefulness of further treatment has not been demonstrated.
5. Treatment of **gastroesophageal reflux disease (GERD)**. Symptomatic relief commonly occurs within one or two weeks after starting therapy. Therapy for longer than six weeks has not been studied.

In active duodenal ulcer; active, benign gastric ulcer; hypersecretory states; and GERD, concomitant antacids should be given as needed for relief of pain.

CONTRAINOICATIONS: Zantac® is contraindicated for patients known to have hypersensitivity to the drug.

PRECAUTIONS:

General: 1. Symptomatic response to Zantac® therapy does not preclude the presence of gastric malignancy.

2. Since Zantac is excreted primarily by the kidney, dosage should be adjusted in patients with impaired renal function (see DOSAGE AND ADMINISTRATION). Caution should be observed in patients with hepatic dysfunction since Zantac is metabolized in the liver.

Laboratory Tests: False-positive tests for urine protein with Multistix® may occur during Zantac therapy, and therefore testing with sulfosalicylic acid is recommended.

Orug Interactions: Although Zantac has been reported to bind weakly to cytochrome P-450 *in vitro,* recommended doses of the drug do not inhibit the action of the cytochrome P-450-linked oxygenase enzymes in the liver. However, there have been isolated reports of drug interactions that suggest that Zantac may affect the bioavailability of certain drugs by some mechanism as yet unidentified (eg, a pH-dependent effect on absorption or a change in volume of distribution).

Carcinogenesis, Mutagenesis, Impairment of Fertility: There was no indication of tumorigenic or carcinogenic effects in lifespan studies in mice and rats at doses up to 2,000 mg/kg/d.

Ranitidine was not mutagenic in standard bacterial tests (*Salmonella, Escherichia coli*) for mutagenicity at concentrations up to the maximum recommended for these assays.

In a dominant lethal assay, a single oral dose of 1,000 mg/kg to male rats was without effect on the outcome of two matings per week for the next nine weeks.

Pregnancy: ***Teratogenic Effects: Pregnancy Category B:*** Reproduction studies have been performed in rats and rabbits at doses up to 160 times the human dose and have revealed no evidence of impaired fertility or harm to the fetus due to Zantac. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

Nursing Mothers: Zantac is secreted in human milk. Caution should be exercised when Zantac is administered to a nursing mother.

Pediatric Use: Safety and effectiveness in children have not been established.

Use in Elderly Patients: Ulcer healing rates in elderly patients (65 to 82 years of age) were no different from those in younger age groups. The incidence rates for adverse events and laboratory abnormalities were also not different from those seen in other age groups.

AOVERSE REACTIONS: The following have been reported as events in clinical trials or in the routine management of patients treated with Zantac®. The relationship to Zantac therapy has been unclear in many cases. Headache, sometimes severe, seems to be related to Zantac administration.

Central Nervous System: Rarely, malaise, dizziness, somnolence, insomnia, and vertigo. Rare cases of reversible mental confusion, agitation, depression, and hallucinations have been reported, predominantly in severely ill elderly patients. Rare cases of reversible blurred vision suggestive of a change in accommodation have been reported.

Cardiovascular: As with other H_2-blockers, rare reports of arrhythmias such as tachycardia, bradycardia, atrioventricular block, and premature ventricular beats.

Gastrointestinal: Constipation, diarrhea, nausea/vomiting, abdominal discomfort/pain, and rare reports of pancreatitis.

Hepatic: In normal volunteers, SGPT values were increased to at least twice the pretreatment levels in 6 of 12 subjects receiving 100 mg qid intravenously for seven days, and in 4 of 24 subjects receiving 50 mg qid intravenously for five days. There have been occasional reports of hepatitis, hepatocellular or hepatocanalicular or mixed, with or without jaundice. In such circumstances, ranitidine should be immediately discontinued. These events are usually

Zantac® 150 and 300 (ranitidine hydrochloride) Tablets
Zantac® (ranitidine hydrochloride) Syrup

reversible, but in exceedingly rare circumstances death has occurred.

Musculoskeletal: Rare reports of arthralgias.

Hematologlc: Blood count changes (leukopenia, granulocytopenia, thrombocytopenia) have occurred in a few patients. These were usually reversible. Rare cases of agranulocytosis, pancytopenia, sometimes with marrow hypoplasia, and aplastic anemia have been reported.

Endocrine: Controlled studies in animals and man have shown no stimulation of any pituitary hormone by Zantac and no antiandrogenic activity, and cimetidine-induced gynecomastia and impotence in hypersecretory patients have resolved when Zantac has been substituted. However, occasional cases of gynecomastia, impotence, and loss of libido have been reported in male patients receiving Zantac, but the incidence did not differ from that in the general population.

Integumentary: Rash, including rare cases suggestive of mild erythema multiforme, and, rarely, alopecia.

Other: Rare cases of hypersensitivity reactions (eg, bronchospasm, fever, rash, eosinophilia), anaphylaxis, angioneurotic edema, and small increases in serum creatinine.

OVERDOSAGE: Information concerning possible overdosage and its treatment appears in the full prescribing information.

OOSAGE ANO AOMINISTRATION: (See complete prescribing information in Zantac® product labeling).

Active Ouodenal Ulcer: The current recommended adult oral dosage is 150 mg or 10 ml (2 teaspoonfuls equivalent to 150 mg of ranitidine) twice daily. An alternate dosage of 300 mg or 20 ml (4 teaspoonfuls equivalent to 300 mg of ranitidine) once daily at bedtime can be used for patients in whom dosing convenience is important. The advantages of one treatment regimen compared to the other in a particular patient population have yet to be demonstrated.

Maintenance Therapy: The current recommended adult oral dosage is 150 mg or 10 ml (2 teaspoonfuls equivalent to 150 mg of ranitidine) at bedtime.

Pathological Hypersecretory Conditions (such as Zollinger-Ellison syndrome): The current recommended adult oral dosage is 150 mg or 10 ml (2 teaspoonfuls equivalent to 150 mg of ranitidine) twice a day. In some patients it may be necessary to administer Zantac® 150-mg doses more frequently. Doses should be adjusted to individual patient needs, and should continue as long as clinically indicated. Doses up to 6 g/d have been employed in patients with severe disease.

Benign Gastric Ulcer: The current recommended adult oral dosage is 150 mg or 10 ml (2 teaspoonfuls equivalent to 150 mg of ranitidine) twice a day.

GERD: The current recommended adult oral dosage is 150 mg or 10 ml (2 teaspoonfuls equivalent to 150 mg of ranitidine) twice a day.

Oosage Adjustment for Patients with Impaired Renal Function: On the basis of experience with a group of subjects with severely impaired renal function treated with Zantac, the recommended dosage in patients with a creatinine clearance less than 50 ml/min is 150 mg or 10 ml (2 teaspoonfuls equivalent to 150 mg of ranitidine) every 24 hours. Should the patient's condition require, the frequency of dosing may be increased to every 12 hours or even further with caution. Hemodialysis reduces the level of circulating ranitidine. Ideally, the dosage schedule should be adjusted so that the timing of a scheduled dose coincides with the end of hemodialysis.

HOW SUPPLIEO: Zantac® 300 Tablets (ranitidine hydrochloride equivalent to 300 mg of ranitidine) are yellow, capsule-shaped tablets embossed with "ZANTAC 300" on one side and "Glaxo" on the other. They are available in bottles of 30 (NDC 0173-0393-40) tablets and unit dose packs of 100 (NDC 0173-0393-47) tablets.

Zantac® 150 Tablets (ranitidine hydrochloride equivalent to 150 mg of ranitidine) are white tablets embossed with "ZANTAC 150" on one side and "Glaxo" on the other. They are available in bottles of 60 (NDC 0173-0344-42) and 100 (NDC 0173-0344-09) tablets and unit dose packs of 100 (NDC 0173-0344-47) tablets.

Store between 15° and 30° C (59° and 86° F) in a dry place. Protect from light. Replace cap securely after each opening.

Zantac® Syrup, a clear, peppermint-flavored liquid, contains 16.8 mg of ranitidine hydrochloride equivalent to 15 mg of ranitidine per 1 ml in bottles of 16 fluid ounces (one pint) (NDC 0173-0383-54).

Store between 4° and 25° C (39° and 77° F). Dispense in tight, light-resistant containers as defined in the USP/NF.

July 1990

Glaxo Pharmaceuticals
DIVISION OF GLAXO INC.
Research Triangle Park, NC 27709

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PROFESSIONAL LIABILITY

COUNTERSUITS: KEEP SWEET REVENGE FROM GOING SOUR

An undeserved malpractice suit evokes thoughts of justice executed by the avenging sword of a countersuit. But countersuits and similar legal actions are not always easy to win, warns Gary Smith, medical liability committee chairman to the Defense Research Institute, an association of civil defense lawyers.

Conversations with his colleagues give Smith the impression that groundless malpractice suits nonetheless are triggering increasing legal counterattacks from physicians and their insurers. The following is his advice on how to launch a successful counterattack.

Appoint an Attorney. Medical liability insurance companies often act against reckless plaintiffs, but the physician who files his own malicious prosecution suit may find a lawyer to take the case for a contingency fee.

Your defense attorney should not handle the case because he probably will be a witness. Instead, look for a lawyer with civil trial experience and at least moderate knowledge about medical matters, Smith says. He suggests getting recommendations from other attorneys and physicians such as neurologists and orthopedists, who generally are experienced at giving depositions because their patients have problems that make lawsuits likely.

Choose your Weapon. Circumstances such as state law may determine which weapon you choose. The most common weapon, according to Smith, is the malicious prosecution suit; it can start after you win the original malpractice suit. Before the malpractice suit is settled, another weapon is available—a countersuit. A Rule 11 sanction also could come into play. In most state and federal courts, Rule 11 of the Federal Rules of Civil Procedure allows a judge to impose heavy sanctions on attorneys who file frivolous lawsuits and motions.

Question Witness Selection. Before filing a malicious prosecution suit, consider that many retaliatory efforts fail because the wronged physician cannot prove that the plaintiff in the malpractice suit knew the suit was groundless. The plaintiff often has an expert witness, so the suit becomes largely a disagreement about medical care.

The chance of winning a retaliatory case improves if your lawyer can show that the other side made insufficient effort to find an expert opinion. Such evidence may not gel, however, until after the malicious prosecution suit is filed.

Beware of Boomerangs. Why not just sue and cause the original plaintiff a little trouble of his own? Before savoring the sweet smell of revenge, remember this warning from Smith: Reckless retaliatory action could permit the plaintiff to file a counter-countersuit or similar legal action.

Though some medical liability insurers may pay such damages, most policies will not. Other protection might come from general business liability or homeowner's insurance.

Seek Signs of Solidity. To avoid losing a malicious prosecution suit, Smith says to watch for hints that you have a solid case. These include the plaintiff asking for dismissal of the malpractice suit or the judge dismissing the suit. Another encouraging situation is the "shotgun suit," where the plaintiff names an unduly large number of defendants. (One plaintiff reportedly sued a passel of hospital physicians including Louis Pasteur; the hospital was on a street named after the renowned scientist.)

Collect your Due. The winner of a malicious prosecution suit usually is compensated for costs of defending the original suit, including time lost while preparing the defense. Though tougher to get, other payments may include punitive damages and compensation for loss of income due to adverse publicity. Typically, plaintiffs have little money, and thus their attorneys' professional liability insurance often pays (Reprinted from *Medical World News,* December 1990).

PREDICTED DATA BANK PROBLEMS ARISE AS SYSTEM STARTS

Despite warnings from the General Accounting Office (GAO) that opening of the National Practitioner Data Bank should be delayed until a number of problems were solved, the Health Resources and Services Administration (HRSA) charged ahead with its scheduled September 1, 1990, launch date.

Now insurance companies, state medical boards, and peer review organizations struggling to conform with reporting requirements, confirm that the system is full of flaws, is burdensome, and is failing to handle the flow of data.

Early assessment of the Bank's operations were not encouraging, reported Lawrence E. Smarr, senior vice-president for statistics and research, Pennsylvania Medical Society Liability Insurance Company.

"In the first six weeks, the Data Bank received 731 claims reports and 108 adverse actions. Only 19 pieces of data have been entered into the Bank. In that same time period 73,767 queries were received and only 12,682 were processed," Smarr said.

Smarr, who serves on the National Practitioner Data Bank Advisory Committee and offered considerable technical advice, said that most claims and adverse action reports are being rejected, often for some minor reason, such as inclusion of cents in payments (a prohibition the Data Bank forgot to include in its instructions). Most reports are being manually reviewed, and in effect, "nothing is going through the computer system."

Smarr, Lori Bartholomew, also of the Pennsylvania company, and Adam Wilczek, vice-president of the Medical Inter-Insurance Exchange of New Jersey, all agreed that the Bank has huge problems with its software.

The Bank is required to report back to those entering data upon its receipt. Ms. Bartholomew said her company had reported 33 claims payments as of mid-November. None have been accepted. In fact, the company was erroneously issued two official identification numbers to place on its submissions. In an exchange of correspondence that is a classic demonstration of bureaucracy at work, Bartholomew tried to set the record straight and designated the number the company would use in reporting and corrected the company's address. She then was notified that both numbers had been nullified. Further correspondence and more telephone calls produced an acknowledgement that one of the numbers will be reactivated, but in the meantime, all of the reports, submitted

under the other number, will come back as rejections and doctors involved will receive two reports for the same payment.

Frustrations are mounting with the inefficient system the Data Bank is using. Wilczek said the reports cannot be generated from the information a company stores on computer nor can the government forms be prepared on computer. The information must be taken off the computer and hand typed onto the forms.

"It is taking approximately 2½ hours to process one report," Wilczek said. Making it possible to report on magnetic tape would simplify the task for many companies and it is hoped that eventually this can be arranged.

Apparently, the Data Bank is adding 15 more data entry people and is working two shifts now and admits it was "inundated with reports." The one area that seems to be working well is the helpline that recently recorded its 10,000th call, but it reportedly is experiencing a 100 percent staff turnover.

GAO warned that the Bank had started off on the wrong foot in a report released August 21, 1990. It said HRSA "failed to follow a sound managerial approach in developing the National Practitioner Data Bank" and that it "has not yet ensured that the Data Bank will protect the confidentiality of practitioner information from unauthorized access and manipulation."

GAO raised serious questions about the usefulness of software programs and concluded that the Bank should not open until all security concerns are satisfactorily addressed and the system has been certified as ready to operate. Shortly after the report was issued, HRSA met with GAO representatives and agreed to conform with some of the recommendations but proceeded with the September 1, 1990, launch date.

Meanwhile, the anticipated disagreements with physicians and reporting malpractice insurers over the narrative in claims reports already are arising, companies said.

Carriers often are providing the narrative, that eventually will come back from the Bank on a pro forma basis, to physicians in advance of submission as a courtesy, and are trying to assure that both parties agree on the facts submitted.

On one point, companies won a round. The government did concede that structured settlements need not be reported retroactively. And, for settlements completed after September 1, 1990, only the amount spent to purchase an annuity needs be reported (Reprinted from *Medical Liability Monitor,* November 28, 1990).

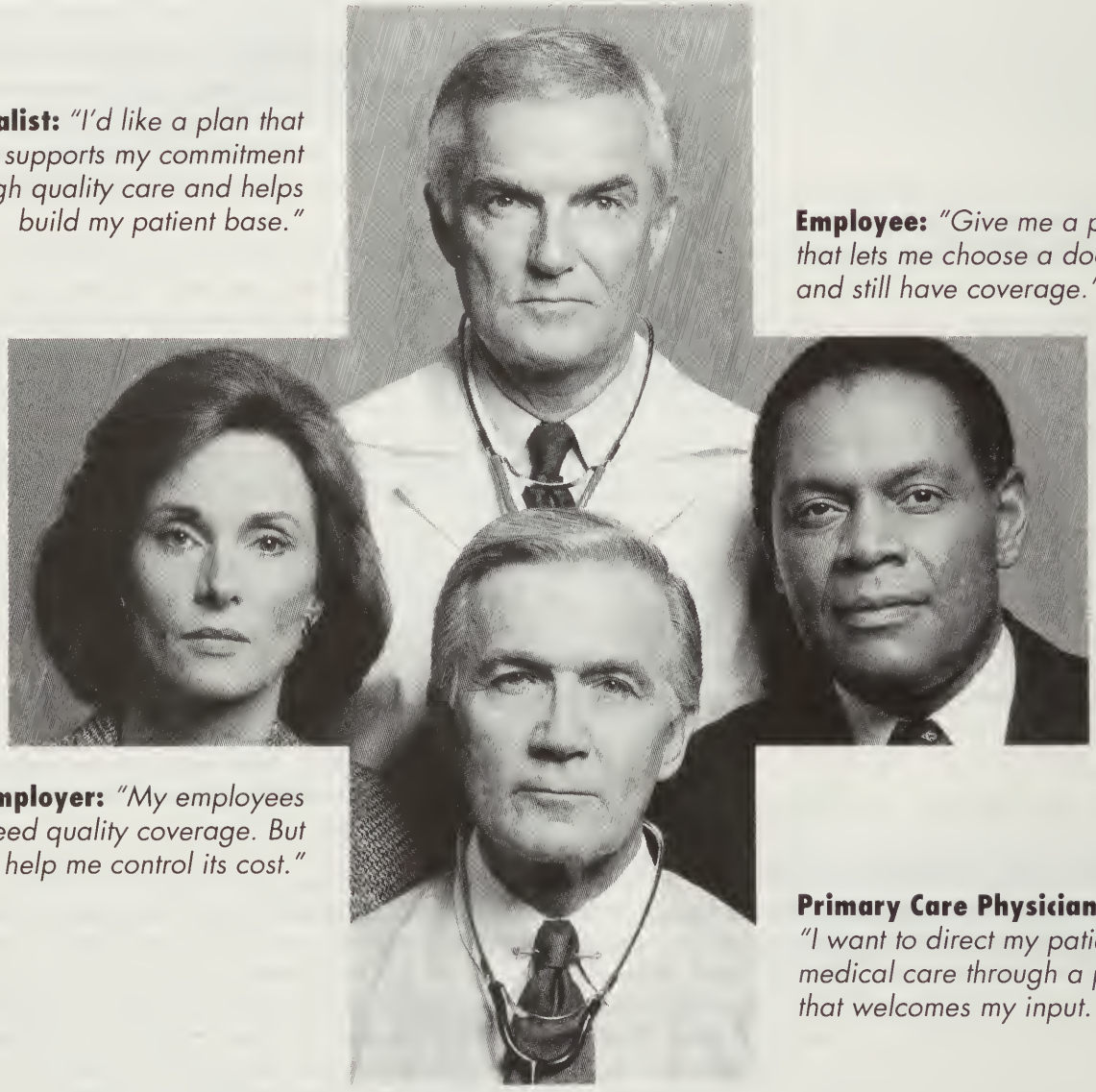
FIVE-YEAR STATUTE OF LIMITATIONS DOES NOT BAR SUIT BY PATIENT

A physician-defendant failed to diagnose a brain tumor discovered in February 1986 and removed. The patient sought damages for the physician's conduct during five years preceding her suit in 1986. The defendant contended that the suit was time barred: it related to his 1978 initial misdiagnosis. A Maryland trial court granted summary judgment. On appeal, it was held that the plaintiff was entitled to challenge the adequacy of the defendant's treatment within the five-year period prior to her instituting suit. The continuing treatment rule does not toll the statute of limitations, but it cannot be used to bar a suit for some period of a physician's conduct just because the conduct began at a time outside the statutory period (Reprinted from *Personal Injury Newsletter,* Vol. 34, No. 12, November 19, 1990).

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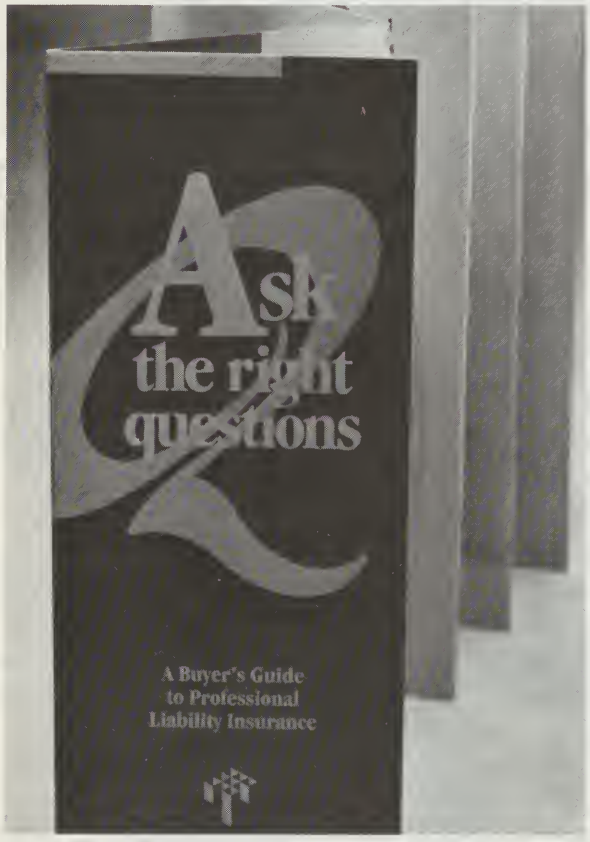
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EDITOR'S DESK

BEWARE THE IDES

In our hearts those of us who know anything worth knowing know that in March a new year begins, and if we plan any new leaves, it will be when the rest of Nature is planning them too. Joseph Wood Krutch, "March," The Twelve Seasons (1949)

March, which blows in like a lion and goes out like a lamb, was not always the third month of the year. Until 1752, when England adopted the Gregorian calendar, March 25 was the first day of the legal and ecclesiastical year in English-speaking countries, although January 1 was popularly accepted as the starting point. Despite the change, domestic leases beginning on March 25 were popular in some areas until the late 19th century.

March was named for Mars, the legendary god of war. Although he was initially considered an agricultural deity, the god of farmers and shepherds, these people, no strangers to combat, converted him to militant status. He is considered the father of the Romans; Romulus and Remus sprang from Mars's tryst with Rhea Sylvia.

March, as befits its origin, is a month that commemorates many military events in our history. The first American nonaggression treaty was signed in 1621, between the Pilgrims and the American Indians; it lasted 50 years. The Boston Massacre—five Americans killed—took place in 1770. Patrick Henry delivered his immortal "give me liberty or give me death" speech in 1775. The United States Constitution finally was ratified in 1789. The act establishing the United States Navy was signed in 1794. The United States Military Academy was founded in 1802. The United States Senate rejected the League of Nations in 1920. (How differently might history have unfolded!) The "Star-Spangled Banner," written in 1814, was adopted as our national anthem in 1931, just 60 years ago (although many would-be singers and others might prefer "America the Beautiful"). The Arab League, whose actions today can have vast influence on the affairs of this nation, was founded in 1945. And the Vietnamese peace treaty was signed in Paris in 1973.

But March also memorializes events without military attributes. A worldwide standard time was first accepted in March 1884. Before that there was chaos; local time was determined by local whim. Our seafaring ancestor, Americus Vespucci, has his birthday honored this month. (We were fortunate not to be the United States of Vespucci.) "Mr. Watson, come here. I want you," was first spoken via telephone in 1876 by Alexander Graham Bell, blessed for his instant communication and cursed for his sometimes unwelcome interruption of peaceful living. This also is the time when many of us, not Hibernian in origin, become honorary wearers of the green to help observe St. Patrick's Day, its parades and its conviviality. And, of course, there is the vernal equinox, the beginning of spring.

More importantly, the end of this month sees the rites of Easter and

of Passover, both of which occur on the last weekend. Although, for years, many felt it inappropriate for these important holidays of two different religions to be solemnized simultaneously, it may be fitting, in today's hoped-for ecumenical world, that togetherness can be not only palatable, but desirable. In this regard, heed the words of Father Andrew M. Greeley, as published in the *New York Times:*

> "We Christians share with our Jewish brothers and sisters the sense that it is possible and necessary to begin again, not only in our relationships to God but also in our relationships with one another and especially in our most intimate loves. That fundamental conviction, a result of God's passionate love for us, binds together Christians and Jews no matter what else may separate us."

Let us hope that this spirit can also encompass Islam, whose followers also believe devoutly in the will of God and in brotherhood.

Finally, we should all give special thanks on March 30 to H.L. Lipman, who, on that date in 1858, put the eraser on the lead pencil, thus confirming, once and for all, the fallibility of the human mind and body. For those of us still computer-illiterate, or addicted to cursive writing or crossword puzzles, Mr. Lipman may have given us one of the greatest gifts of all, the ability to hide our mistakes. □

> Ignorance is a blank sheet, on which we may write, but error is a scribbled one, on which we must first erase.
>
> Charles Caleb Cotton, *Lacon* (1825).

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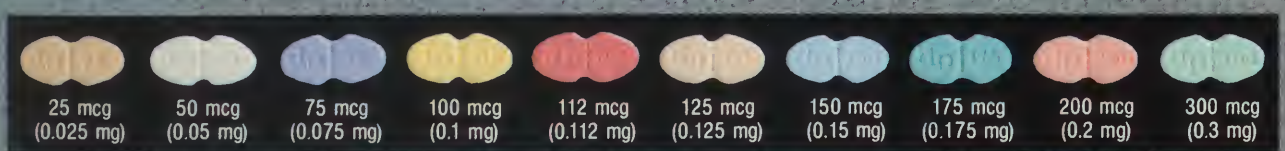
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CONTRAINDICATIONS:
L-thyroxine therapy is contraindicated in thyrotoxicosis, acute myocardial infarction and uncorrected adrenal insufficiency.

WARNINGS:

Drugs with thyroid hormone activity, alone or together with other therapeutic agents, have been used for the treatment of obesity. In euthyroid patients, doses within the range of daily hormonal requirements are ineffective for weight reduction. Larger doses may produce serious or even life-threatening manifestations of toxicity, particularly when given in association with sympathomimetic amines such as those used for anorectic effects.

PRECAUTIONS:
Caution must be exercised in the administration of this drug to patients with cardiovascular disease. Development of chest pains or other aggravation of the cardiovascular disease requires a reduction of dosage.

Patients on thyroid preparations and parents of children on thyroid therapy should be informed that replacement therapy is to be taken essentially for life. They should immediately report during the course of therapy any signs or symptoms of thyroid hormone toxicity, e.g., chest pains, increased pulse rate, palpitations, excessive sweating, heat intolerance, nervousness, or any other unusual event. In case of concomitant diabetes mellitus, the daily dosage of antidiabetic medication may need readjustment. In case of concomitant oral anticoagulant therapy, the prothrombin time should be measured frequently to determine if the dosage of oral anticoagulants is to be readjusted.

Partial loss of hair may be experienced by children in the first few months of thyroid therapy, but this is usually a transient phenomenon and later recovery is usually the rule.

Drug Interactions — In patients with diabetes mellitus, addition of thyroid hormone therapy may cause an increase in the required dosage of insulin or oral hypoglycemic agents.

Patients stabilized on oral anticoagulants who are found to require thyroid replacement therapy should be watched very closely when therapy is started.

Cholestyramine binds both T_4 and T_3 in the intestine, thus impairing absorption of these thyroid hormones. Four to five hours should elapse between administration of cholestyramine and thyroid hormones.

Estrogens tend to increase serum thyroxine-binding globulin (TBG). Patients without a functioning thyroid gland who are on thyroid replacement therapy may need to increase their thyroid dose if estrogens or estrogen-containing oral contraceptives are given.

Drug/Laboratory Test Interactions — The following drugs or moieties are known to interfere with laboratory tests performed on patients taking thyroid hormone; androgens, corticosteroids, estrogens, oral contraceptives containing estrogens, iodine-containing preparations, and the numerous preparations containing salicylates.

Carcinogenesis, Mutagenesis, And Impairment of Fertility — A reported apparent association between prolonged thyroid therapy and breast cancer has not been confirmed. No confirmatory long-term studies in animals have been performed to evaluate carcinogenic potential, mutagenicity, or impairment of fertility in either males or females.

Pregnancy-Category A — The clinical experience to date does not indicate any adverse effect on fetuses when thyroid hormones are administered to pregnant women.

Nursing Mothers — Minimal amounts of thyroid hormones are excreted in human milk. Thyroid is not associated with serious adverse reactions and does not have a known tumorigenic potential. However, caution should be exercised when thyroid is administered to a nursing woman.

Pediatric Use — The incidence of congenital hypothyroidism is relatively high. Routine determinations of serum (T_4) and/or TSH is strongly advised in neonates in view of the deleterious effects of thyroid deficiency on growth and development.

ADVERSE REACTIONS:
Adverse reactions are due to overdosage and are those of induced hyperthyroidism.

OVERDOSAGE — Excessive dosage of thyroid medication may result in symptoms of hyperthyroidism, which may not appear for one to three weeks after the dosage regimen is begun. The most common signs and symptoms of overdosage are weight loss, palpitation, nervousness, diarrhea or abdominal cramps, sweating, tachycardia, cardiac arrhythmias, angina pectoris, tremors, headache, insomnia, intolerance to heat and fever. If symptoms of overdosage appear, discontinue medication for several days and reinstitute treatment at a lower dosage level.

Complications as a result of the induced hypermetabolic state may include cardiac failure and death due to arrhythmia or failure.

Dosage should be reduced or therapy temporarily discontinued if signs and symptoms of overdosage appear.

Treatment of acute massive thyroid hormone overdosage is aimed at reducing gastrointestinal absorption of the drugs and counteracting central and peripheral effects, mainly those of increased sympathetic activity. Measures to control fever, hypoglycemia, or fluid loss should be instituted if needed.

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BOOK REVIEWS

AIRWAY RESPONSIVENESS AND ATOPY IN THE DEVELOPMENT OF CHRONIC LUNG DISEASE

Scott Weiss, MD, and David Sparrow. New York, NY, Raven Press, 1989. As there is a heightened awareness of the increasing mortality with obstructive airway disease, such as asthma, it is becoming more important to understand the pathophysiology of these disorders. Chronic obstructive pulmonary disease (COPD) is the fifth leading cause of death in the United States. Based on the statistics that 90 percent of COPD patients have a prior history of smoking, but only 20 percent of smokers develop COPD, this book pursues the hypothesis that other factors are involved in the development of COPD, e.g. airway responsiveness and atopy (mast cell hypersensitivity). The book is divided into ten chapters including the immunology of the allergic response and inflammation, methods to assess airway responsiveness, and allergy as well as genetics. The last several chapters focus on these processes in the pathophysiology of various clinical disorders such as asthma, occupational airway disease, and cystic fibrosis. The book is recommended for clinicians interested in assessing the present association between airway hyper-responsiveness, the inflammation associated with mast cells (allergic response), and chronic airflow obstruction. □ Leonard Bielory, MD

BOYD'S TEXTBOOK OF PATHOLOGY

A.C. Ritchie. Philadelphia, PA, Lea & Febiger, 1990. This classical textbook of general pathology is an excellent indepth review of all areas of general pathology. There are 2,000 pages with 62 chapters and well-illustrated photographs.

The initial chapter on the history of pathology and its application to all areas of medicine is particularly well done. Each disease entity discussed in the textbook is described in detail, including the characteristic clinical presentations and etiology in addition to the pathology. Where necessary, electron microscopy is well described and well illustrated. The chapter on electrolyte imbalance is particularly well prepared. In noting the current literature in such disease states as acquired immunodeficiency syndrome, Lyme disease, and current classifications of lymphoma, the textbook is most current and up to date. All chapters are well referenced with easy-to-define bibliographies. This textbook will join several other current textbooks on pathology as an example of a general review of pathology.

This textbook is well suited for medical school students, and for practitioners of medicine in all specialties to give a broad overview of the disease states with which they are dealing. □ William V. Harrer, MD

CANCER CHEMOTHERAPY BY INFUSION

Jacob J. Lokich, MD (ed). Chicago, IL, Precept Press, 1990. Cancer chemotherapy can be administered by several routes, including oral, intramuscular, intracavitary, and intravenous. The latter may be accomplished in either bolus fashion or by prolonged, continuous infusion. This book considers the principles and applications of infusion chemotherapy.

Sophisticated pharmacokinetic studies have established rationales for dose scheduling and delivery for antineoplastic agents and for different

cancers, and there exists a large body of published scientific literature on the subject in the oncology library. Nowhere, however, except in this book, is all the complex information pertaining to infusion therapy readily available and dealt with in as clear and concise a manner.

The editor, Dr. Lokich, is regarded in some oncology circles as the "maven" of infusion therapy, and the 50 contributors represent a wide spectrum of competent basic scientists, pharmacologists, educators, and clinicians. This second edition of the compendium updates advances in the field, including the use of biologic response modifiers and hematopoetic growth factors, and newer applications of combination chemotherapy. New chapters on cell kinetics and chronobiology are included. Monitoring blood levels of antineoplastic agents as a means of optimizing antitumor effects and minimizing host toxicity also is considered. References are included up through 1989, making publication timely.

Although the clinical status of infusional chemotherapy remains undefined, and cost considerations and complexity of application thus far limit widespread acceptance of the technique in many clinical situations, the subject deserves study and this book retains value for the practicing oncologist. □ Alan J. Lippman, MD

THE ICU BOOK

Paul L. Marino, MD. Philadelphia, PA, Lea & Febiger, 1991. The author has done an outstanding job of presenting enormously complex physiological and clinical information for critical care patients in a reasonably concise book of 713 pages. The author also has included many appendices at the end of this well-outlined and comprehensive presentation of critical care medicine.

Dr. Marino prepared this work as a way of unifying critical care medicine, that has undergone a systematic compartmentalization process over the years. The author states in the preface: "In recent years, the trend has been away from a unified approach to critical illness, as the specialty of critical care becomes a hyphenated attachment for other specialties to use as a territorial signpost. The landlord system has created a disorganized array of intensive care units (ten different varieties at last count), each acting with little communion. However, the daily concerns in each intensive care unit are remarkably similar because serious illness has no landlord."

It appears that Dr. Marino has successfully accomplished his goal of presenting the common ground in critical care medicine rather than the specific interests of each intensive care unit. The author has succeeded in presenting a generic book covering all intensive care units. *The ICU Book* is a text to be studied at length and in great detail as well as to be used as a handy reference guide. It is by no means casual or quick reading. The author is to be commended for this work. □ James E. George, MD, JD

NEOPLASMS WITH ECCRINE DIFFERENTIATION

If you ever wanted a textbook that told you all you ever wanted to know about neoplasms with eccrine differentiation, this is it. This well-organized text is a first in a series of monographs dealing with all facets of cutaneous neoplasia.

The glossary of cutaneous tumor terminology is most interesting. There is a very logical progression from benign eccrine tumors to malignant neoplasms. The chapter, "Principles of Diagnosis in Dermatopathology," is exceptionally well done. Not only are individual cutaneous units well defined, but they also are very well photographed starting at what is

termed pattern analysis progressing from low power to high power. This indepth review is of particular value to dermatologists, dermatopathologists, and surgical pathologists with an interest in cutaneous pathology. Each chapter is particularly well organized. In the chapter enumeration, I particularly was interested in the section entitled mucinous carcinoma, a very unusual condition that can mimic metastatic disease.

The authors specifically comment about their meticulously prepared glossary stating that the language of neoplasms in general and of neoplasms with eccrine differentiation in particular is replete with indecipherable, vague, and faulty words, terms, and phrases. The doctors attempt to compensate for and rectify these defects by preparing a glossary that is as complete and definitive as possible.

This is a superior prepared monograph on the topic of neoplasia with eccrine differentiation. □ William V. Harrer, MD

COMPUTED TOMOGRAPHY OF THE BODY

John Haaga and Ralph J. Alfidi (eds). St. Louis, MO, Mosby-Year Book, 1990. This second edition of the popular two-volume encyclopedic review incorporates the use of high-resolution, fourth-generation computed tomography (CT) scanning images and power contrast injector techniques. This update completes a highly extensive and sophisticated treatment of the field. Each organ system is considered with the utmost detail, and ample displays of high-quality images enhance the text.

The sections of the first volume are devoted mainly to CT of the central nervous system. The chapters include discussions of congenital anomalies, tumors, trauma, and demyelinating diseases. The complexities of the skull base are skillfully handled, with attention given to the orbit and sella. The second volume addresses all areas of body imaging from the thorax and heart to the pelvis. The commentary on the lungs encompasses such topical subjects as differentiation between benign and malignant lung nodules. Diagnosis of entities such as hemangiomas, focal nodular hyperplasia, and adenomas highlights the chapter on the liver. Of particular note are the lucent articles covering the pancreas, adrenal glands, and kidneys. With the growing reliance on CT to diagnose disorders of the musculoskeletal system, the emphasis on CT staging in the section on osseous malignancies hits the mark. This area receives less attention in the book than other parts. Nonetheless, each chapter is quite complete in its probing of each organ system. In addition, pediatric imaging and biopsy techniques also are explored.

The editors have compiled a broad and readable selection for the interested physician. The text is a highly worthwhile investment. □ Neil B. Horner, MD

THE SPORT PARTICIPATION FITNESS EXAMINATION

W. Ben Kibler, MD. Champaign, IL, Human Kinetics Books, 1990. This spiral-bound book is a very complete and thorough guide for the physician, especially the school physician, responsible for preparticipation physical examinations of the athlete. Included in the book are chapters covering the physical examination and the philosophy behind it, suggested forms to use, and specific sports-related skills to test with illustrations. Illnesses requiring special consideration such as diabetes, asthma, and cardiovascular problems are addressed as well as gender considerations. One very useful chapter covers the criteria for restricting sports activity when indicated, and counseling the athlete. The final chapter deals with some of the legal aspects performing this type of examination and includes some useful forms and letters to use. The book is recommended. □ Christine E. Haycock, MD

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LETTERS & VIEWPOINTS

SLOT MACHINE SYNDROME

One of my patients is an 85-year-old white male who complained of chest pain and right arm pain. He had a medical history of angina pectoris and had undergone successful angioplasty for right coronary artery. On history taking, I was impressed that the patient may have an episode of angina pectoris with relation of this pain to right arm. However, on further history taking, the patient told me that he was in Atlantic City and he played slot machines at a stretch of more than three and one-half hours. He had no other history of any injury, of doing any other heavy work, or of working in the yard.

Physical examination revealed that his blood pressure was normal. His pulse was 70 beats/min. Examination of his chest revealed the patient had musculoskeletal tenderness in the anterior chest and examination of arms showed he had a subcutaneous hematoma measuring 5 cm x 5 cm in the upper arm on the right side extending to antecubital fossa. His electrocardiogram was unchanged from the previous one.

After listening to his history and putting everything together, I am convinced this patient has sustained injury by playing slot machines for a prolonged period of time and most probably ruptured one of the subcutaneous vessels leading to subcutaneous hematoma. The patient was advised not to go to a casino for some time. He was given analgesics and cold compresses; in a week's time his hematoma disappeared and he had no more chest pain or right arm pain.

I have taken the liberty of calling this kind of injury, in which there is a subcutaneous hematoma on the right arm accompanied with chest pain and prolonged exposure to slot machines, by the name, slot machine syndrome.

All chest pains radiating to arms are not angina pectoris in elderly patients. □ A. Kumar, MD

AMATEUR RADIO OPERATORS

Once again, physicians will be placed in a very difficult position because of bureaucratic decrees by the federal government. The Federal Communications Commission (FCC) is responsible for the criteria used for licensure of amateur radio operators. For political reasons, the FCC has decreed that handicapped individuals may request waiver of the requirement to learn Morse code in order to achieve a certain class of license.

Of course, one must submit a "physician's certificate stating that, due to a severe handicap under the 1988 Developmental Disabilities Act, 29 USC 706 (15) (A) (III), the examinee is unable to meet the 13 or 20 WPM requirement." Further, the physician must submit a release allowing FCC access to appropriate medical records.

Aside from the obvious considerable controversy that this has created among the amateur radio community, the physician now is obligated to try to understand what this means. There is an organization in Minnesota, Handi-Hams, that encourages and trains handicapped individuals to become licensed amateur radio operators, regardless of the handicap.

Handi-Hams is very much against this waiver procedure.

May I suggest that the average physician in the state of New Jersey does not know what the term "severely handicapped individual" means in accordance with the above identified Act, nor could he be expected to know what effect these disabilities may have for an individual interested in learning Morse code. Thus, the physician may feel that he will do his patient "a favor" by signing such a certificate just to accommodate his patient's request.

I strongly urge the physicians of New Jersey not to summarily sign such a certificate. Rather, if you are asked about this, please request appropriate advice from a local licensed amateur radio operator, preferably another physician. □ Edward N. Ludin, MD

DON'T SIGN THE LETTER

The letter from Dr. Ludin is important; it will convey crucial information to New Jersey physicians asked to provide letters for handicapped individuals excusing them from the FCC requirement to learn Morse code to obtain a higher degree of amateur radio license.

Totally handicapped quadriplegics have mastered these requirements as well as blind or deaf individuals, and the psychological benefits of this achievement are immeasurable. There are, however, some rare instances where an individual cannot meet this goal, hence, the FCC edict. Only a person familiar with both medicine and amateur radio can make this determination correctly. Our plea to our colleagues is to ask other physicians or medically oriented "Hams" as well as to contact the Medical Amateur Radio Council for information before signing the needed letter for an individual.

I, therefore, urge the members of the Medical Society of New Jersey to contact anyone of us to aid in making the determination. □ Christine E. Haycock, MD

AMATEUR RADIO LICENSING

The individual who upgrades an amateur radio license by a doctor's note, waiving the Morse code test, in this case to upgrade certain amateur radio privileges, then will be stigmatized as having a disability in learning Morse code, when in fact he might have succeeded on his own, if assisted and encouraged.

With help, his impairment of having no hands, or a stroke, or being quadriplegic but able to key with his mouth, would not be a disability. What the difference is, in self-esteem, you can realize yourself in comparing the two approaches. Greater wisdom is on the side of the agency that supports self-realization to the fullest.

There is a trend now toward regarding Morse code as obsolete, when it is not, and in emergencies with weak signals or equipment failure, this simpler mode saves lives because it gets the message through. The entry-level speed for licensing has been 5 words/minute, a Boy Scout speed.

Amateur radio is not "like CB" as nontechnical people mistakenly associate this latter untrained use of radio. Ethics, laws, operating procedures, and engineering basics are part of amateur licensing. It is a discipline that becomes a worldwide fraternity, making strangers into first-name acquaintances in a few minutes.

This year the Federal Communications Commission (FCC) is changing the entry-level licenses to eliminate a Morse code requirement. The higher grades are unaffected, except by the ruling of December 27, 1990, exempting handicapped applicants from the 13 and 20 words per minute

Morse code examinations. In other words, a handicapped person already will have a license—of entry level. He will be seeking a physician's note to upgrade to higher privileges without passing a Morse code test, that others must pass, although he will have to pass an additional written test on laws and theory of more advanced nature.

The ruling says, "Only certification by doctors of medicine and osteopathy will be accepted." Applicants also will be required to submit a release allowing FCC access to appropriate medical records. This regulation took effect February 14, 1991. Who will provide the release? What will it say?

Ham radio is a popular hobby among physicians, and you should be able to find a member of your staff to answer further questions before being a "nice guy" and signing a note you do not understand.

In your library, browse through *QST* magazine, published monthly by the American Radio Relay League to understand why this human/technical hobby is important to your impaired patient. He can talk to the world from his wheelchair.

I wish the FCC would have talked directly to physicians first. In dealing with the FCC, we are "nice guys" too. □ Morris Soled, MD

LETTERS TO THE EDITOR

Letters to the editor are welcome. The editor-in-chief will review all comments on articles published in *NEW JERSEY MEDICINE,* as well as concerns for the physician community and the health care industry. Please address letters to Howard D. Slobodien, MD, Editor-in-Chief, *NEW JERSEY MEDICINE,* Two Princess Road, Lawrenceville, NJ 08648. □

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Estrogen Replacement for the 1990s

JEROME ABRAMS, MD, MPH

Estrogen replacement therapy (ERT) probably is the fountain of youth for postmenopausal patients today. However, the majority of physicians are unwilling or unable to convince the majority of their patients to accept ERT,[1] except possibly on a short-term basis to alleviate the hot flashes and flushes of menopause.[2] While the beneficial effect of ERT upon the high-density lipoprotein/low-density lipoprotein (HDL/LDL) ratio has not been proved conclusively to decrease coronary artery disease, its beneficial effect upon the skeletal and lower urogenital systems has been demonstrated and proved for decades.[2,3]

There are two reasons why most patients are unwilling to accept much more than short-term therapy: fear of cancer,[1,4] specifically endometrial and breast cancer, and unwillingness to deal with the uterine bleeding that ERT usually evokes.[4,5] However, physicians responsible for the care of more than 35 million menopausal and postmenopausal women have an obligation to try to decrease the incidence of osteoporotic fractures caused by estrogen deprivation, numbering over 400,000 annually including over 250,000 hip fractures[2,3] with a mortality rate of over 10 percent within 12 months of the injury.[5-7] Resistance to more frequent use of long-term ERT can be overcome by (1) patient education with facts rather than anecdotes about endometrial and breast cancer;[1,4,8] (2) appropriate diagnostic monitoring to insure that liability and potential risks are minimized;[1,2] and (3) individualized yet simplified management.[1]

Dr. Abrams is clinical professor of obstetrics/gynecology, UMDNJ-Robert Wood Johnson Medical School, and is affiliated with Muhlenberg Regional Medical Center, Plainfield. This paper was submitted in August 1990 and accepted for publication in October 1990. Requests for reprints may be addressed to Dr. Abrams, 346 South Avenue, Fanwood, NJ 07023.

EDUCATION

Endometrial cancer. The woman whose uterus has been removed for benign disease need not be concerned with endometrial cancer, but the woman with her uterus should be informed of the following:

1. ERT previously had been associated with an increased incidence of endometrial cancer. Since progestins were added to the regimen several years ago, this association has been negated[1,7] and ERT with progestins seems to be protective against endometrial cancer; the incidence of endometrial cancer actually may be higher among those not taking any hormonal replacement.[7,8] 2. In the unlikely event that endometrial cancer were to occur, the cure rate is nearly 90 percent[8,9] for the general population and even higher among those patients under surveillance because of hormonal replacement. 3. The incidence of hip fracture is over seven times greater[2,9] than the incidence of endometrial cancer (with a recovery rate nearly three times greater than that of hip fracture).[6,7]

Breast cancer. The fear of breast cancer has been fueled by the periodic appearance of reports suggesting its association with ERT. Although there probably are more reports refuting this association,[2,8,10] these reports do not attract the publicity that the indictments attract. The controversy over ERTs causative relationship with breast cancer most recently was renewed by the publication of a Swedish study[11] and an American study,[12] each of which suggested an increased risk of breast cancer among users of exogenous estrogens. Nevertheless, the latter still concluded that although ERT "may modestly increase risk" the skeletal and cardiovascular benefits outweigh this risk.[12]

Contraindications to ERT. Complications and potential litigation can be avoided or at least minimized if the following contraindications to ERT are heeded: history of breast and/or endometrial cancer; impaired liver metabolism; severe hypertension; pregnancy; gallbladder disease; undiagnosed uterine bleeding; and thromboembolic disease or history thereof.[2,7,8] Common sense dictates that any of these or any other potentially serious medical problem demands resolution before embarking upon a program of prophylactic medication like ERT. There exists a relative contraindication omitted from this list because of conflicting opinions about its significance: mammary dysplasia or adenosis or dense glandular breasts[13]—three synonymous terms employed by radiologists to indicate mammography that is not entirely normal. Many radiologists add the following warnings to their reports: "Dysplasia may conceal an underlying malignancy," and/or "Mammography has a 5 to 10 percent false negative rate." While dysplasia may not represent an absolute contraindication to ERT in the academic or scientific community, in the real world of litigious patients these signals from the radiologist should be heeded by the prudent clinician, especially if there are additional risk factors for breast cancer such as family history, nulliparity, or parity after age 30.[2]

DIAGNOSTIC MONITORING

Monitoring procedures will serve to identify those patients who stand to benefit most from ERT and those patients for whom ERT represents a risk.

1. Mammography is recommended for all women over age 40 and actually insisted upon for all ERT candidates.[1,2,8] The safest and wisest course of action is to follow the guidelines of the American Cancer Society and advise a baseline study at age 35, particularly with a high-risk patient, and frequent mammography after age 40.[14] There is no agreement about the frequency of mammography after age 40 but certainly annual mammography for all ERT patients is necessary.[14]

2. Endometrial sampling is required for the ERT patient who has a uterus to be sampled, but there is no unanimity of opinion about the frequency of sampling—probably once a year providing there is no irregular bleeding.[1]

3. Bone densitometry or computed tomography (CT) scan will provide objective evidence of incipient or actual osteoporosis.[1,15] There are conflicting opinions about the merits of bone densitometry versus CT scan. Much of the opinion and ultimate decision depends upon availability, cost effectiveness, and confidence in the physician with a specific machine. Clinical judgment is more cost effective and almost as accurate, particularly with the petite, sedentary, cigarette-smoking white or oriental woman who is an obvious candidate for osteoporosis,[15,16] an objective test is advisable for those patients with relative contraindications and/or resistance to ERT.[1] Finally, there are two simple measures in addition to routine physical examination and blood pressure determinations: measuring height at each office visit to detect evidence of collapsing vertebrae, and evaluating serum lipid profiles.[1,2,8] Decreasing height and unfavorable HDL/LDL ratios may tip the balance toward ERT for certain reluctant patients.[16]

MANAGEMENT

1. Primary prevention generally is more successful and infinitely more cost effective than active treatment of a particular disease. Cessation of cigarette smoking,[1] an increased intake of dairy products,[2] and weight-bearing exercises serve to decrease the rate of calcium loss that starts insidiously after age 35.[7] Continuation of these measures will benefit the cardiovascular and skeletal systems.

2. Secondary prevention or active management should be seriously considered for every menopausal patient below age 70.[17] Unless there are specific contraindications and/or significant risk factors for breast cancer, ERT (0.625 mg of conjugated estrogen daily for 21 to 25 days each month) without progestins is an inexpensive and well-tolerated regimen for the woman whose uterus has been removed for benign disease.[2,16] Dosage may be reduced if mastalgia and/or molimina are annoying.[1] Estrogen cream instillations once a week may be added at the onset of ERT if dyspareunia and/or stress incontinence are present so that the vagina may retain or regain its tone and moisture. The salutory effects obtained by estrogen cream upon the lower urogenital tract will be appreciated by all concerned and may even serve to overcome prejudices about hormones in general, particularly for the patient resisting oral estrogens. Vaginal instillations with Replens®, a nonhormonal cream, supplements the once-a-week routine with estrogen cream.

During the perimenopausal phase, it is not always certain that ovarian function finally has disappeared. For the woman who still has her uterus, a ten-day course of progestins (10 mg daily) once a month is recommended and again serves to overcome prejudices about hormones.[8] When there is no longer any withdrawal bleeding after one or more courses of progestins and there are no risk factors whatsoever for breast cancer, there need be no hesitation on the part of the physician to inform such a patient of the benefits of ERT with progestins and to prescribe with confidence. The standard "state of the art" regimen during the past ten years has been the aforementioned monthly course of conjugated estrogens (0.625 mg daily for 21 to 25 days) plus

progestins (10 mg daily) during the last 10 to 13 days of the 21 to 25 day course.[1,2] Even though ERT with progestins serves to be protective against the occurence of endometrial cancer[7,8] many women, including those with risk factors for osteoporosis, will discontinue therapy once uterine bleeding occurs and uterine bleeding probably will occur with this cyclic regimen. Herein lies the explanation for the second reason why so many menopausal patients[5] and their physicians are reluctant to accept ERT—their unwillingness to deal with uterine bleeding.[8] Consequently, many physicians who are convinced that the benefits of ERT outweigh the potential risks have been trying out a continuous rather than a cyclic regimen of ERT with 2.5 mg of progestin in an effort to avoid cyclic withdrawal bleeding.[8] Although this regimen has been satisfactory for many patients, the occasional occurrence of "breakthrough bleeding" frequently is more difficult to evaluate and monitor than the expected withdrawal bleeding that occurs during the week without hormones on the cyclic regimen.

Endometrial sampling, the specific procedure for monitoring the uterine bleeding that occurs with ERT and progestins, can be performed readily and easily without antecedent gynecologic training by means of one of several inexpensive, pliable plastic samplers.[1] After obtaining the customary cytologic samples from the posterior vaginal fornix, endocervix, and exocervix, the endometrial sampler is introduced into the endometrial cavity through the cervical canal; once withdrawn, its adherent cells are smeared out for Papanicolaou fixation in the same manner that the previous cytologic samples were treated. The sampler then is vigorously stirred in a small container of 10 percent formalin for a cell block. The pathologist, as well as the gynecologist, with whom the family physician or internist is acquainted will respond readily to questions regarding choice of sampler, timing of sampling, and other details of technique as well as results of microscopic examination of submitted samples. If the cervical canal resists introduction of the endometrial sampler, gynecologic referral becomes necessary.

Uterine bleeding during the week without hormones is to be expected and can be monitored by endometrial sampling at the time of the annual or semi-annual physical examination with routine vaginal and cervical cytology. Breakthrough or unexpected bleeding requires prompt endometrial sampling; repeated episodes require a telephone consultation with the pathologist or gynecologist in anticipation of a diagnostic curettage.

For most menopausal patients, particularly those at risk for osteoporosis, uterine bleeding should be an acceptable inconvenience in return for proved benefits to the skeletal system,[2] a satisfactory HDL/LDL ratio, a youthful lower urogenital tract, and a general feeling of well-being. ERT may be continued almost indefinitely as long as no contraindications exist; and monitoring procedures are permitted. CT scan or bone densitometry to provide objective evidence of incipient osteoporosis may be reserved for those with relative contraindications to ERT and/or those with uneasiness about uterine bleeding. Menopausal patients without contraindications deserve to be informed of the benefits of ERT. The benefits of ERT after the age of 70 are questionable and not worth the trouble and expense.[17]

SUMMARY

The benefits of ERT outweigh the potential disadvantages and risks for the majority of menopausal and postmenopausal women. The preventive measures described for premenopausal women should benefit their cardiovascular and skeletal systems. ■

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Prevention of Menopausal Sequelae

GLORIA A. BACHMANN, MD

One of the greatest challenges to achieving optional health care delivery to the older woman lies in the expansion of premenopausal preventive health services—specialized services directed to midlife women so that the many postmenopausal pathologies linked to long-term loss of estrogen can be ameliorated or prevented.

Women live longer than men, and, therefore, more females reach geriatric ages than males; this advantage does not extend to morbidity. Although life expectancy for women is about seven years greater than that for men, a woman's sixth, seventh, and eighth decades are marked by many medical problems and physical dysfunctions, resulting in a greater frequency of ambulatory medical visits, hospitalizations, and nursing home residencies.[1,2] Compared to men, postmenopausal women have a higher incidence of several medical conditions: varicose veins, urinary stress incontinence, cystocele and other diseases of the urinary system, migraine headaches, constipation, gallbladder disease and other intestinal conditions, thyroid disorders, anemia, and osteoporosis.[2,3] After menopause, women also lose their advantage in the incidence of cardiovascular disease.[4,5] Cardiovascular disease rarely occurs in women before they experience the transition from premenopausal to postmenopausal status, but after menopause, more women die from cardiovascular disease than men.[4] In fact, the major cause of death by a substantial margin among postmenopausal women in the United States is cardiovascular diseases, including heart disease and stroke. Heart disease accounts for nearly 53 percent of all deaths in women over 50 years of age and also has a major impact on morbidity and health care expenditures.[5] In 1986, 337,024 United States women compared to 333,348 men died of ischemic heart disease or cerebrovascular disease.[6] And, although antihypertensives, cardiovascular medications, surgical procedures—both invasive and noninvasive—as well as lifestyle modification can be beneficial in extending life and improving the quality of life in women diagnosed as having cardiovascular disease, medical emphasis should be directed at preventing cardiovascular disease rather than treating it.

The burden and challenge to physicians caring for midlife women is to address and prevent early dysfunctions resulting from menopausal changes so geriatric women will have optimal health throughout their lives. Patient care of the midlife woman and medical research need to address the changes that occur due to menopause and aging and the impact of related factors such as diet, exercise, lifestyle (smoking, drugs, and alcohol), medication (drugs, hormones, and vitamins), social environment, education, and availability of counseling and community resources.[7] We hope to prevent postmenopausal disease rather than just to treat it.

OVARIAN CHANGES OF THE MIDLIFE

The midlife period of a woman, the climacteric, is hallmarked by declining ovarian function. Unlike

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the male, who has the ability to produce gametes throughout life, the female is born with a set number of follicular units—maximum at 4 to 5 million units at 20 weeks' intrauterine life—and these gametes will never duplicate.[8] At birth, the gamete number is reduced to approximately 2 million units and by puberty the germ cell mass is further reduced to approximately 300,000 units. During the next 35 to 40 years, these gametes are depleted through ovulation and through atrophy; at the time of the last menses, there may be only a few thousand unresponsive units remaining in the ovary.

However, even before the actual loss of menstrual periods, the follicular units are depleted sufficiently in most women so that the quantity of hormone and the rhythmic cyclicity of hormone production that mark the early reproductive years are diminished or lost. This period of a woman's life characterized by follicular depletion sufficient to cause hormonal changes is defined as the climacteric. The climacteric period, spanning several years, often is divided into three periods: early (premenopause, ages 35 to 45 years); mid (perimenopausal, ages 45 to 55); and late (postmenopausal, ages 55 to 65).[9,10]

Problems during the early climacteric years include dysfunctional uterine bleeding, premenstrual syndrome, and relative infertility. The perimenopausal years are dominated by progressive hormonal withdrawal characterized by menstrual disorders, vasomotor instability, psychological changes, and related sensory symptoms and target tissue atrophy resulting in atrophic vaginitis, bladder dysfunction, urethritis, and cystitis. These perimenopausal symptoms often bring women into the health care system and are an optimal time to institute preventive health care measures. The late climacteric or postmenopausal years are characterized by the long-term sequelae of estrogen deprivation with marked atrophy and dysfunction of all estrogen sensitive tissues and organs, especially of the urogenital, skeletal, and cardiovascular systems.

Since the effects of the estrogen deficiency extend beyond the reproductive system, many authorities consider the climacteric an endocrinopathy. The effect of this deficiency is not solely the absence of menses but encompasses a spectrum of adverse signs and symptoms (dyspareunia; blood-stained discharge; pruritus vulvae; pelvic prolapse; urinary frequency and urgency; stress incontinence; dryness of skin, hair, and mucus membranes; central nervous system symptoms such as behavioral changes, sleep disorders, and loss of peripheral sensitivity; psychological concerns; skeletal fractures; loss of height and altered body contour; and cardiovascular disease). Therefore, menopause is an endocrinopathy, since there is a morphologic change in an endocrine gland (the ovary); there is an alteration in the hormone milieu; receptor tissues are affected by these hormone changes; and patients present with clinical signs and symptoms from these hormonal changes.[11]

PREVENTIVE MEASURES

Awareness of climacteric issues. The midlife woman who comes into the health care system may be treated for a specific complaint without incorporating the cause of the complaint into the total medical picture of the climacteric. For instance, a woman with complaints of vaginal irritation may be offered medication for infection when in reality estrogen deprivation and inadequate vaginal lubrication are the cause of her vaginal complaints, or sedatives, tranquilizers, or narcoleptics may be used for insomnia when the etiology is vasomotor instability (night sweats) interfering with a restful sleep. Early correction of dysfunctions brought on by menopausal changes often have the best results when intervention is begun early. For instance, nursing home utilization in the geriatric female population may be decreased with early diagnosis and treatment of urinary stress incontinence, a leading reason for institutionalization of the elderly, second only to dementia.[12] With the passage of time, symptoms of urinary stress incontinence often exacerbate, or the woman's medical condition deteriorates so that medical and surgical interventions no longer are possible or are not as effective in treating the problem. Also, many times climacteric problems cannot be solved in an office visit and may require extensive counseling or other ancilliary services such as physical therapy. Awareness of support services in the community can be useful in preventing many of the debilitating emotional and physical conditions that may be developing during this time.

Hormone replacement therapy. If the climacteric period is considered an endocrinopathy, then replacing the deficient hormone by exogenous means is an appropriate method of treatment. The hormones used in replacement therapy, that vary in formulation, dosage, schedule of use, and routes of administration, produce benefits as well as side effects and risks.[11] The benefits include elimination of short-term menopausal symptoms such as hot flushes, night sweats, insomnia, emotional and memory dysfunctions, and prevention of long-term problems such as urogenital atrophy, osteoporosis, coronary heart disease, and sexual dysfunctions. Side effects of hormone therapy include nausea, fluid retention, mastalgia, reinstitution of menstrual bleeding, and increased necessity for surgical intervention, i.e. endometrial biopsy, dilation and curettage. Morbidity also includes an increased risk of uterine cancer (if estrogen is given without a progestational agent when the uterus still is present)

and thromboembolic and gallbladder problems. The issue of hormone replacement therapy and breast cancer still is not resolved and the existing literature is divided. All women started on estrogen replacement therapy (ERT) should have a thorough breast check and a mammogram.

From current data, it appears that optimal therapy with hormone replacement therapy lowers the mortality rate and enhances feelings of well-being and quality of life.[13,14] Ongoing studies, such as the PEPI study (Postmenopausal Estrogen/Progestin Interventions), involving more than 800 women at seven centers around the country, will provide more information on hormonal replacement risks and benefits.

Most women are given ERT for the control of annoying symptoms since estrogen effectively reduces vasomotor, somatic, and associated psychological symptoms. It may be more important to give hormones to the asymptomatic woman to prevent chronic disease such as those that affect the skeletal and cardiovascular system. ERT is recommended for menopausal women considered at high risk for cardiovascular disease.[15] Until recently, ERT was mistakenly equated with the use of oral contraceptives that contain higher dosages of synthetic estrogen and progestins, and, therefore, ERT is felt to increase cardiovascular problems. Today, the lower doses of estrogen in the low-dose oral contraceptive pills have been shown to have a reduced risk of untoward cardiovascular events. ERT in middle age and older women appears to impart no cardiovascular risk whatsoever. Substantial evidence suggests the opposite—that estrogen is cardioprotective.[15] With hormone therapy, blood pressure is lowered, total and low-density lipoprotein cholesterol levels are reduced, and the high-density lipoprotein cholesterol level is increased. The incidence of angina and myocardial infarction also is lower in estrogen users than in nonusers and overall mortality rates from cardiovascular disease appear to be reduced as well.[15]

The cause-and-effect relationship between estrogen and skeletal health first was noted by Fuller Albright who highlighted the importance of ovarian failure in the pathogenesis of osteoporosis.[17] This has been substantiated by the discovery that osteoblasts appear to express classical estrogen receptors and that osteoporosis is a primary disorder of the skeleton consequent to loss of estrogen to these cells.[18,19] Overwhelming evidence supports the concept that adequate estrogen therapy can retard menopausal acceleration of bone loss.[20] Estrogen deficiency has been shown to be the major factor causing bone loss in the aging female population.[21]

Exercise. There is increasing evidence that physical activity and physical fitness are directly correlated with a decreased risk of many diseases, e.g. coronary heart disease, stroke, hypertension, obesity, diabetes, colon cancer, depression.[22] Although most of the data on exercise and disease have been derived from studies in men, an extensive eight-year perspective study, involving over 3,000 women, showed that physical fitness was inversely associated with morbidity and mortality from several chronic diseases in women as well.[23] Data revealed that exercise resulted in an overall decrease in mortality from all causes.

The initial step in designing a health maintenance exercise plan for the climacteric woman is a complete medical evaluation.[24] In those instances where history and physical examination reveal problems, further evaluation including a 12-lead ECG and exercise tolerance test challenging the cardiovascular system, the respiratory system, and the endurance of the lower extremities also should be utilized. To be most effective, a prescribed program must provide precise, written instructions for the type, intensity, duration, and frequency of exercise.[25,26] Structured exercise programs with a commitment to specific times, days, and place, with or without other participants, are most effective.

Diet. Overeating can be as detrimental as undernourishment in the preservation of health. Overeating may include foods that lack essential nutrients but contain large amounts of sugar, saturated fats, salt, cholesterol, phosphates, and calories. Overweight persons are more likely to develop obesity, heart disease, high blood pressure, atherosclerosis, strokes, arthritis, osteoporosis, gastrointestinal cancers, diverticulitis, colitis, and cirrhosis of the liver.

In additon to emphasizing the intake of adequate fiber, proteins, minerals, and vitamins to the midlife patient, it also is essential to counsel her to control caloric intake. Caloric requirements decrease by about 2 to 4 percent each year with aging so that the average 30-year-old woman can consume 2,000 k/cal per day; by age 50 she can consume 1,800 k/cal per day and by age 75 she can consume 1,600 k/cal per day. Recommended daily allowances for the maintenance of good nutrition for climacteric women have been established by the National Research Council.[28] Guidelines should be available to patients so that nutritional adjustments can be made.

Midlife medicine. It is difficult to curtail or stop detrimental habits that have been integrated with a person's lifestyle without intensive therapy. Medical care designed for midlife, especially for those women at risk because of lifestyle or diet, chronic disease, or genetic predisposition to dysfunctions that occur with aging, may be the most effective way of preventing adverse sequelae of menopause.[29,30]

With the use of specialized antepartem clinics, there has been a dramatic decrease in maternal and infant morbidity and mortality.[31] "Midlife medicine" may be a way to lessen the morbidity that accompanies the extra years medical technology has added to a woman's life. In addition to addressing medical concerns, intensive counseling and education often are important in preventing disease progression. "Midlife medicine" practiced either in a doctor's office or in a hospital center, could tailor health care to the midlife woman's special needs. Prompt diagnosis and treatment during the early climacteric years can improve the quality of life for many women and help to prevent the adverse long-term consequences of the menopause.

Several midlife studies currently are taking place in the Department of Obstetrics and Gynecology, UMDNJ-Robert Wood Johnson Medical School. These include vaginal moisturization studies using nonhormonal preparations, the effect of estrogen on bone density, and the testing of different estrogen delivery systems and progestational agents. Hopefully, these studies will not only continue to contribute knowledge to this area of climacteric health but at the same time prevent many postmenopausal problems. ■

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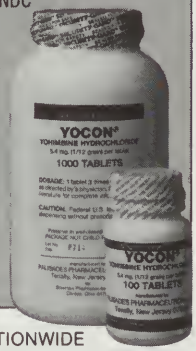
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Tracheal Papillomatosis

Molecular Diagnostic Techniques and Human Papilloma Virus

KUMUDINI U. MEHTA, MD
PAUL J.P. BOLANOWSKI, MD
NICHOLAS COMBATES
KAREL RASKA, JR, MD, PhD

Papillomatosis, the formation of multiple confluent papillomas, has been noted at various sites throughout the respiratory tract. This condition presents predominantly during childhood as multiple papillary growths confined to the larynx. Juvenile papillomas usually have a benign, self-limited course and only rarely do they spread to involve the lower trachea and bronchi. Primary papillomatosis of the lower respiratory tract is extremely rare in adults.[1-9] Cases usually occur following laryngeal involvement or after tracheostomy.[10-14] These neoplasms are strongly associated with infection with the human papilloma virus (HPV) types 6/11. HPV 11 originally was cloned from a laryngeal papilloma and since has been found in genital papillomas, as well as in mild dysplasia of the uterine cervix. Although HPV type 6 originally was isolated from a condyloma of the uterine cervix, it also has been documented in a significant number of patients with laryngeal papillomas.[15,16]

We report a rare presentation of multiple tracheal papillomatosis without laryngeal involvement in a 64-year-old female with a longstanding history of asthma. She underwent surgery in 1980 and presented with recurrence of tracheal papillomatosis 10 years later. Molecular probe analysis of the biopsy specimen showed the presence of human papilloma virus (6/11) genome in the tumor tissue. We hypothesize that longstanding asthma with disruption of airflow and excessive mucus production eventually may have caused squamous metaplasia, which in turn became the site for HPV tropism and papilloma formation.

Drs. Mehta and Raska, and Mr. Combates are affiliated with the Department of Laboratory Medicine and Pathology, and Dr. Bolanowski is affiliated with the Department of Surgery, UMDNJ-New Jersey Medical School. This paper was submitted in August 1990 and accepted in December 1990. Requests for reprints may be addressed to Dr. Mehta, UMDNJ-New Jersey Medical School, 185 South Orange Avenue, Newark, NJ 07103-2757.

CASE REPORT

A 64-year-old female presented with progressive dyspnea and wheezing. She had asthma for 15 years with a history of tracheal papillomas, surgically resected in 1980. Physical examination of this admission showed bilateral inspiratory and expiratory wheezing and stridor. Complete blood count, SMA-12, electrolytes, and urinalysis were within normal limits. Chest x-ray showed cystic lesions in the parenchyma of both lungs. Computed tomographic (CT) scan of the chest revealed multiple polypoid tracheal lesions present throughout the trachea down to the carina. Multiple cystic lesions were noted in parenchyma with an air-fluid level in one on the right (Figure 1). Fiberoptic bronchoscopy demonstrated multiple, friable, papillary lesions dif-



Figure 1. CAT scan of the chest demonstrating multiple papillomas of the trachea and cystic lesions in both the lung parenchyma.

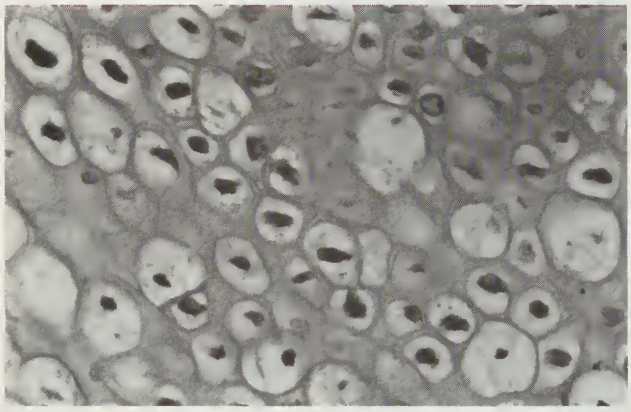


Figure 2. A histologic section of tracheal papilloma with koilocytotic change (hematoxylin and eosin original magnification x 400).

fusely involving the trachea to the carina. Excisional biopsy of all the lesions was performed via a rigid bronchoscopy. Postoperatively, the patient was placed on Clindamycin® intravenously and Mefoxin®. Mefoxin® was discontinued on day 10 and Clindamycin® was continued for a total of 16 days. A repeat CT scan showed no gross change in the cystic lesions and complete patency of the trachea. The patient was discharged free of symptoms.

MATERIALS AND METHODS

The papillary tumors from the tracheal biopsy specimen were routinely fixed in 10 percent buffered formaldehyde solution and embedded in paraffin. In addition to routine hematoxylin and eosin slides, additional sections, 4 microns thick, were floated onto poly-L-lysine coated glass slides. In situ DNA hybridization was performed as described by Unger using biotinylated probes for HPV types 6/11, 16/18, and 31/32/35 (Life Technologies Inc., Gaithersberg, MD).[17] Positive hybridization was identified by incubation with a streptavidin-alkaline phosphatase

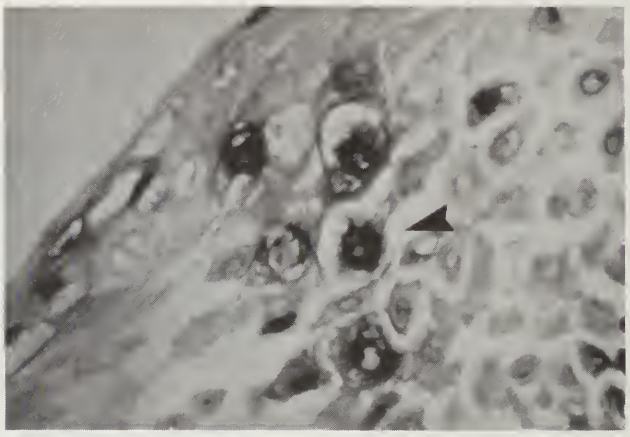


Figure 3. In situ DNA hybridization for human papillomavirus types 6/11 in tracheal papilloma is shown. The arrow indicates one of the cells positive for HPV types 6/11 signal (colorimetric detection as described in the text with concentrated nuclear fast stain counterstain, original magnification x 400).

complex. The slides were colorimetrically developed and were lightly counterstained with concentrated nuclear fast red. Biotinylated probes for human genomic DNA and pBR322 plasmid DNA were used as positive and negative controls, respectively.

PATHOLOGIC FINDINGS

Gross examination revealed multiple small papillary lesions ranging from 0.2 to 0.4 cm. Microscopical examination showed multiple papillary structures lined by squamous epithelium. The epithelial cells showed orderly maturation with marked koilocytotic change and some nuclear atypia (Figure 2). The papillomas showed strong positivity with a biotinylated DNA probe for HPV types 6/11 (Figure 3), but were negative for the other HPV types tested. Under hybridization conditions performed under lower stringency, weak signals also were seen for HPV types 16/18 but not for types 31/33/35 (not shown).

COMMENT

Respiratory papillomatosis is a rare condition encountered worldwide. Most commonly, it presents with recurrent involvement of the larynx of children. These papillomas are benign neoplasms consisting of a central fibrovascular connective tissue core covered by squamous epithelium. They have been reported at all sites throughout the respiratory tract; from nasal vestibule to the lung parenchyma. Usually, tracheal papillomas follow spread from preexisting laryngeal papillomas, following tracheostomy or exposure to environmental irritants, e.g. tobacco smoking. Primary tracheal papillomatosis, however, is extremely rare without these associated factors.

The suspected etiology of recurrent respiratory papillomatosis is infection with HPV. HPV is a het-

erogeneous group of DNA viruses with a circular double-stranded genome well known to infect squamous epithelium and characteristically to produce proliferative mucosal lesions associated with epithelial growth showing little or no keratinization. Currently, more than 50 different strains of HPV are recognized, each of which has had its DNA sequences cloned. Infection by some strains has been clearly associated with an increased frequency of malignant transformation in the infected epithelial cells. Possibly, the most dramatic example is noted with epidermodysplasia verruciformis where infection with HPV types 5, 8, and 14 is associated with the development of squamous cell carcinoma of the skin. Another example is the genital tract, where at least 14 different HPV strains have been detected but only a few strains have been shown to be oncogenic. Whereas cervical dysplasia has been detected to have HPV types 16/18/33/35, invasive squamous cell carcinomas of the cervix are associated with types 16/18/33. HPV types 6/11 have been reported to be associated with respiratory papillomatosis. HPV type 11 has been reported in squamous cell carcinoma of the lung associated with chronic laryngotracheobronchial papillomatosis.[15]

A recent animal study by Shikowitz has shown a possible relationship between tracheostomy-induced squamous metaplasia and the appearance of tracheobronchial papillomatosis.[18] Since HPV has specific tropism for squamous mucosa, it is assumed that squamous metaplasia either precedes or occurs concurrently with the development of papilloma.

In our case report, longstanding asthma with superimposed bronchitis may have given rise to disruption of airflow due to excessive mucus production and hypertrophy of submucosal glands with goblet cell hyperplasia and eventual squamous metaplasia. This metaplastic epithelium may be the site for HPV tropism and papilloma formation.

Steinberg's study of 20 patients with laryngeal papillomatosis noted the presence of HPV DNA in uninvolved sites in the respiratory tree and in patients in clinical remission.[19] Because of this, complete removal of all the papilloma tissue during surgery does not eliminate all infected cells and, therefore, new papillomas may grow.

Even after surgical removal, patients with papillomatosis need regular evaluation, and any recurrent growth should be biopsied and studied for presence of viral sequences.

The malignant potential of a respiratory papilloma is unknown. However, animal models with cervical papillomas have shown that HPV's interact with other cellular or viral oncogenes.[20] The study of expression of cellular oncogenes in this tumor tissue is in progress. ■

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Physician Office Laboratory Regulations

KATHLEEN L. VOLDISH, CLA (ASCP)

As of January 31, 1991, all laboratories including physician offices needed a chemical hygiene plan (CHP) in place to meet OSHA regulations.

There are two OSHA standards that apply to all physician office laboratories (POLs): the "Hazardous Communication Standard of 1987" and the "Occupational Exposure to Hazardous Chemicals in Laboratories Standard." The occupational exposure standard encompasses the regulations of the hazardous communication standard and expands upon the safety requirements. Once the new law is in practice in the office setting, it supersedes the previous OSHA regulation.

The purpose of these standards is to develop good chemical safety and chemical hygiene habits in a POL setting. These laws have been created for the legal protection of the physician and the health protection of employees. Physicians must take the time to meet the requirements of these standards. When OSHA begins to inspect POLs, physicians found in noncompliance will face citations and possible fines. This article will summarize the main components of these OSHA standards.

Ms. Voldish is a registered technologist and laboratory manager, and POL consultant. Requests for information or programs can be addressed to Ms. Voldish, 1150 Concord Drive, Haddonfield, NJ 08033.

OSHA STANDARDS

As of August 1, 1988, all laboratories, regardless of size, were required by OSHA to have a written hazardous communication program in place if chemicals were housed in the facility and handled by the employees. Most POLs have diagnostic analyzers that use reagents that fall under this heading. Stains, fixatives, preservatives, and some injectables, i.e. chemotherapy, also would be included.

The following three steps will help the physician to understand and to comply with this OSHA standard: First, an inventory list of all chemicals considered hazardous must be compiled. The quantity stored per month/year, physical state (solid, liquid, or gas), manufacturer's name and address, and chemical hazard classification should be documented. Second, a material safety data sheet (MSDS) manual must be organized. MSDS sheets often are supplied by the manufacturer when chemicals are ordered. Letters will have to be written to request MSDS from all others. If you are unsure whether a chemical is classified hazardous—get the MSDS and read it. If it is not classified, you can discard the sheet or keep it for reference in case the chemical is questioned in the future. MSDS should be put in alphabetical order and indexed. The manual should be reviewed periodically and additions and deletions made. This manual is individualized for each office, and must be accessible to all employees. Third, the physician is to provide employees with a hazard communication educational program. This training can be incorporated into the training program that will be required for the new occupational exposure standard. Training always should be supplied within 30 days of employment and before an employee handles any chemicals that could be hazardous to his health. Objectives to be covered in this training should include: location and identification of potentially hazardous chemicals; how to read and understand chemical labels; where the MSDS manual is and how to use it; when to use protective clothing, i.e. gloves, goggles, masks; and procedures to follow for chemical spills. Completion of this training should be documented, signed by the physician, and permanently retained in the employee's file.

CHEMICAL HYGIENE PLAN

As of January 31, 1991, all laboratories including POLs are required to have a chemical hygiene plan (CHP) in place. The contents of this occupational exposure standard simply expands the contents of the hazard communication standard to cover more areas of safety training and safety manual documentation.

Requirements for a CHP in a POL setting are:

1. All standard operating procedures relevant to safety and health considerations must be written in a manual.

2. Protective measures must be available to reduce exposure, including written instructions on the use of gloves, goggles, masks, and laboratory wear.

3. Instructions are necessary if the office has a flow or bio-hazard hood, including ways to check if the hood is functioning properly.

4. A glossary of chemical terminology is appropriate.

5. Provisions for the employees' "right to know" training are required; this would be the contents of the program developed under the hazard communication educational program covered earlier in this article.

6. Provisions for medical attention for an employee after an accidental chemical or blood exposure should be stated; it is the physician's legal obligation to provide this service.

7. An office employee should be delegated to assume the responsibility for implementation of training, updating manuals, and documentation of training and accidents.

8. Instruction for the disposal of all hazardous waste generated by the office is necessary. This service often can be provided through the hazardous waste company the physician uses.

9. A formal policy statement written and signed by the physician stating his responsibility to provide safety training to the employees and maintain a safe working environment should be documented in each employee's file.

Most of this information can be found in any laboratory safety manual. The program then can be developed and implemented by the employer. Once documentation and program are in place, it is easy to update and maintain. Collecting the information and developing the training program can be difficult for the busy physician. Often physicians find it easier and cost effective to hire a laboratory consultant experienced in this area to organize the complete program. The consultant usually can compile the information and provide training in two or three visits. Videotapes about safety can be purchased to assist in training.

SUMMARY

Physicians must not ignore the OSHA standards. All physicians should meet the requirements now and then they will feel confident that they have provided their employees with a safe working environment. ■

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Asbestosis in New Jersey

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ALLISON TEPPER, PhD
RUKMANI RAMAPRASAD, MS
GWENDOLYN SOLICE-SAMPLE, BA

A survey was conducted of 1,079 individuals reported by New Jersey hospitals to the New Jersey State Department of Health. Forty-eight percent of the respondents indicated that they had not received financial compensation for their work-related disease; 415 different sources of exposure to asbestos were identified.

Some of the earliest mortality studies of lung cancer and asbestos exposure in the United States were of workers in a New Jersey asbestos insulators union[1] and of workers from a Paterson asbestos insulation manufacturer.[2] New Jersey was the site of many asbestos products manufacturers and several large shipyards, all of which used asbestos, and New Jersey has been the residence of many individuals who worked in neighboring shipyards in Pennsylvania and New York. Most of these industries have closed or no longer use asbestos, yet the legacy of disease will continue into the next century.

The New Jersey State Department of Health (NJDOH) monitors asbestos-related diseases as part of its occupational illness and injury surveillance program.[3] This paper reports the results of a survey of New Jersey patients with asbestosis; the purpose of the survey was to identify characteristics and needs of these individuals so NJDOH could plan for appropriate public health interventions.

The authors are affiliated with the New Jersey State Department of Health. The paper was submitted in August 1990 and accepted in October 1990. Requests for reprints may be addressed to Ms. Stanbury, New Jersey State Department of Health, CN 360, Trenton, NJ 08625-0360.

METHODS

Since October 1985, all nonfederal acute care hospitals in New Jersey have been required to report occupational lung diseases including asbestosis

directly to NJDOH. In 1988, followup activities for the asbestosis cases were designed. In response to each report received, NJDOH sent a letter to each individual with a discharge diagnosis of asbestosis asking him to complete a brief questionnaire. In February 1989, the cover letter, questionnaire, and postage-paid return envelope were sent to all individuals reported from 1985 through 1988. The questionnaire asked whether the patient had ever been told he had asbestosis, names of the companies where asbestos exposure took place, information on workers' compensation or other legal claims the patient may have filed, and whether the patient wanted further medical or legal information about asbestosis.

RESULTS

NJDOH sent a cover letter and questionnaire to 1,079 individuals discharged with a diagnosis of asbestosis reported by New Jersey hospitals between October 1985 and December 1988. Ninety-five letters (9 percent) were undeliverable. Of the 984 delivered questionnaires, 448 questionnaires (45 percent) were returned completed. Ninety-seven (22 percent) of the 448 returned questionnaires were completed by proxy respondents because the asbestosis patients were deceased (Table 1).

Sex, race, and age were available from the hospital reports on all 1,079 individuals. The sex and race distributions of the 448 respondents were the same as the 631 nonrespondents (92 percent male, 91 percent white). The mean age of the respondents, 69.3 years, was similar to that of nonrespondents, 69.7 years. The distribution of respondents and nonrespondents by year of discharge was similar for all years surveyed.

Eighty-one respondents (18 percent) indicated "no" to the question, "Have you ever been told that you have asbestosis?"; 4 respondents (1 percent) indicated "Don't know" to the question; and 18 respondents (4 percent) left the question unanswered. Two of the 4 respondents who indicated they did not know they had asbestosis, noted they had been exposed to asbestos, 1 of the 4 persons noted he had mesothelioma, and 1 of the 4 persons noted he had pleural plaques (Table 2).

Three hundred forty-seven individuals (including 7 individuals from "no" and "don't know" groups) identified a total of 415 sources of asbestos exposure, including 154 different companies. Seven persons noted exposure came from living with a family member who worked with asbestos. Sixty-one individuals noted more than one source. Table 3 shows the industrial categories [two-digit Standard Industrial Classification (SIC) code] where exposures took place. SIC 32 (stone, clay, and glass manufacturing, including asbestos products) and SIC 37 (transportation manufacturing, including shipbuilding) accounted for 23 percent and 38 percent of the 415 exposure sources, respectively. Within SIC 32, the Manville Corporation was specifically cited 51 times, accounting for 55 percent of the 93 exposure sources cited within SIC 32 and 12 percent of the 415 total exposure sources. The largest shipyard in New Jersey, that closed in 1968, was cited most often among the 14 shipyards named (71 times; 45 percent of all shipyard citations). Among other manufacturing SIC groups, a major chemical company was cited 29 times, and 3 major petroleum refining companies were each cited more than 1 time. Twenty-seven exposure sources were in SIC 40-92; these are outside of the manufacturing/construction sectors, and include four schools, two hospitals, and one prison.

Of the 353 individuals who responded to the question of whether they had ever filed a worker's compensation claim, 104 persons (30 percent) said yes. Fifty-six of these 104 individuals (54 percent) were awarded worker's compensation benefits, 25 individuals (24 percent) were denied benefits, 17 individual cases (16 percent) were pending, and 6 persons (6 percent) did not specify claim status. Three hundred

Table 1. ***New Jersey State Department of Health asbestosis patient survey.***

Questionnaire Response Rates			
Total delivered questionnaires			984 (91%)
Completed questionnaires		448 (45%)	
Completed by patient:	351		
Completed by proxy:	97		
No response		536 (55%)	
Letter undeliverable			95 (9%)
		Total questionnaires sent	1,079 (100%)

thirty-six individuals responded to the question of whether they had filed any other type of claim or legal suit; 136 persons (40 percent) said they had filed claims. (Information on the status of the award for other legal claims was not obtained.) One hundred seventy-two of the 360 individuals (48 percent) who had responded to either question had not filed any type of claim (Figure 1).

Three hundred twenty-nine individuals responded to the question about the need for more information about asbestosis. Two hundred ninety-eight individuals (90 percent) indicated they would like additional medical and legal information.

DISCUSSION

The sources of exposure cited by the survey respondents were consistent with sources cited by other studies and reference guides, including those describing sources by industrial categories[4] and those listing producers or processors by name.[5] Self-reported sources of exposure may be biased as a result of memory loss, lack of knowledge of actual exposure, or other factors.

Stone, clay, and glass manufacturing (SIC 32), shipbuilding (SIC 37), chemical manufacturing (SIC 28), and petroleum refining (SIC 29) accounted for a large proportion of cases, as did construction trades that included asbestos insulation workers. An earlier study of potential asbestos exposure in New Jersey identified 16 major asbestos products manufacturing plants in SIC 32.[6] Twelve of those 16 companies and an additional 8 companies in SIC 32 were identified by this survey. In the earlier study, eight major shipyards were identified, four of which were identified in this survey. A study of lung cancer and occupations in New Jersey has attributed 5 percent of all lung cancer in New Jersey to work in shipbuilding, after adjusting for smoking, and as much as 17 percent in Camden, the city that had the largest concentration of shipbuilding in the state.[7]

In this survey, 27 of the self-reported exposure sources were identified as nonindustrial workplaces. Further followup is needed to define exposures, occupational characteristics, and the clinical findings of those patients who noted nonindustrial settings as the source of their exposure. Physicians should take into consideration the potential for asbestos exposure in such settings.

Even for individuals with a disease as clearly associated with work exposure as asbestosis, nearly half of the respondents had not filed for any kind of financial compensation. This percentage may be as high as 58 percent if the 88 individuals not responding to the questions on compensation or legal claims were assumed to have not filed any claims (259 of 448 persons versus 172 of 360 persons). In an earlier study of compensation for asbestos-related deaths among asbestos insulators,[8] 57 percent of the deaths involved neither a lawsuit nor a worker's compensation claim. Seventy-one percent of the widows interviewed who did not file a claim cited "no knowledge," either of the cause of the worker's illness or death or of the legal entitlements, as the reason no legal claim was filed. In spite of much publicity about asbestos disease in the ten years since that study, our survey shows that knowledge among asbestos workers or their next-of-kin about financial compensation may be little changed. For silicosis, another well-defined occupational disease that has received less public attention than asbestosis, the percentage of patients or widows seeking compensation has been found to be even less (33 percent).[9]

In our survey, 90 percent of the respondents indicated a need for more medical and legal information. In response, NJDOH distributed an informational packet to these 298 individuals and will continue to provide this information to all asbestosis cases reported to NJDOH under state reporting regulations. NJDOH's response also may include in-

Table 2. ***New Jersey State Department of Health asbestosis patient survey.***

Questionnaire Responses:
"Have you ever been told you had asbestosis?"

	Number of Patients	Percent of Patients
Individuals answering "yes"	345	77
Individuals answering "no"	81	18
Individuals answering "don't know"	4	1
No response to question	18	4
Total Respondents:	448	100

Table 3. ***New Jersey State Department of Health asbestosis patient survey.***

Self-Reported Asbestos Exposures by Industry Categories

Standard Industrial Classification Code	Industrial Group	Number of Exposure Sources Reported	Number of Different Companies Reported
12	Mining	1	1
17	Construction—special trades	32	32
20	Food manufacturing (mfg)	1	1
28	Chemical mfg	35	6
29	Petroleum refining	16	10
32	Stone, clay, glass, and concrete mfg	93	20
33	Primary metals mfg	7	6
34	Fabricated metal products mfg	3	3
36	Electrical equipment mfg	6	6
37	Transportation equipment mfg*	159	14
40	Railroad transportation	3	3
48	Communication services	1	1
49	Electric and gas services	7	7
50	Wholesale trade—durable goods	1	1
59	Miscellaneous retail	1	1
73	Business services	1	1
75	Automotive repair	1	1
80	Health services	4	4
82	Educational services	7	7
92	Public administration—justice	1	1
—	Company name but industry category indeterminable	28	28
—	Family contact	7	NA
	Total	415†	154

†Greater than total number of patients responding (N=347) because some patients indicated more than one exposure source.
*All citations were in shipbuilding.

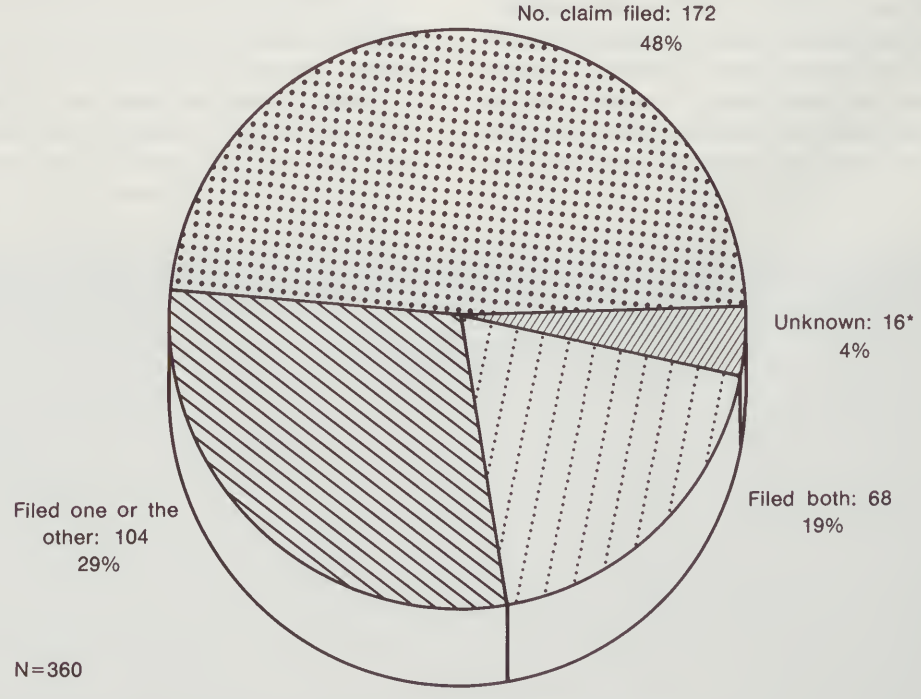


Figure 1. Distribution of patients filing worker's compensation or other legal claims. *Incomplete Data

vestigation of ongoing asbestos exposure, where appropriate.

Hospital discharge data only identify hospitalized patients with asbestosis. The only effective way for NJDOH to identify nonhospitalized asbestosis patients for inclusion in its public health responses is to receive reports from physicians. Physician reporting of all occupational lung diseases became mandatory as of May 21, 1990, under N.J.A.C. 8:57-3.2.

Eighteen percent of our survey respondents said they had no knowledge of having asbestosis. Without additional followup, we do not know how many of these cases were coding errors by the hospitals and how many had not been informed of, or had been informed but had not understood, the diagnosis.

We do not know whether results of this survey would have been significantly different if we had been able to obtain data from a larger percent of reported patients. Given that the age, race, and sex distributions of the respondents and nonrespondents were similar, we suspect that there would not have been major differences.

Studies of national data have suggested that the burden of asbestos disease on health will continue to increase into the first decade of the next century.[5,10] Given the extensive manufacture and use of asbestos products in New Jersey, workers with asbestos-related disease probably will have a major impact on the medical and legal system in this state for many years. This probability is supported by data from New Jersey hospital discharges showing a marked upward trend in the number of patients with asbestosis discharged from New Jersey hospitals, increasing steadily from 186 persons in 1979 to 677 persons in 1986 with no significant change in the total number of hospital discharges over these eight years.[11] Two studies have noted excess numbers of patients with asbestosis[12] and deaths due to asbestosis[13] in New Jersey relative to other states.

Physicians who diagnose and treat asbestosis or other asbestos-related diseases need to inform patients both of relevant medical information and of their legal rights and responsibilities. For example, patients need to know that there are statutes of limitations for filing worker's compensation or third-party claims, usually two years from the time of diagnosis. In a recent report by the Institute of Medicine concerning the role of primary care physicians in occupational medicine, one of the proposed minimum standards of care for all primary care physicians was to "be sensitive to the ethical, social, and legal implications of the diagnosis of and intervention for occupational . . . disease."[14] The results of this survey suggest a need for increased efforts on the part of physicians who treat occupational disease patients in New Jersey to meet this standard.

CONCLUSION

New Jersey carries a large burden of asbestos disease. Our survey corroborates previous studies that found much of the associated financial burden is borne primarily by asbestosis patients themselves rather than by worker's compensation or employers' liability insurance.[8,15] The prevalence of asbestosis and other asbestos-related diseases is estimated in other studies to be likely to increase in the near future.[5,10] Physicians have responsibilities to educate patients on the social and legal aspects of asbestos-related disease and to make appropriate referrals, including referrals to NJDOH for followup. ■

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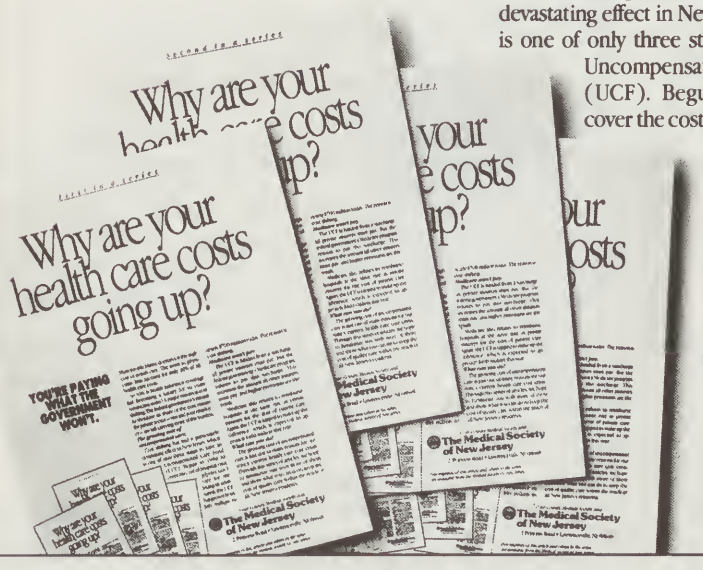
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Complications of Caustic Ingestion

A. ARIF, MD
MONROE S. KARETZKY, MD

The ingestion of caustic substances by children usually is accidental, whereas in adults the ingestion of caustic substances usually is with suicidal intent.[1] Caustic substances are strong acids or alkalis capable of burning or destroying living tissue. The corrosive substance most frequently swallowed is a highly concentrated solution of potassium or sodium hydroxide, lye.[2] The complications are immediate and delayed and, consequently, the management varies according to the time elapsed from the initiating event. In 1967, lye became commercially available in the liquid form replacing the household use of granules. This product evolution has increased the incidence of damage to the esophagus and proximal gastrointestinal tract resulting from ingestion. The pathology, extensive complications, and therapeutic goals will be reviewed and an illustrative case presented.

CASE REPORT

A 28-year-old male football player was seen in the emergency room 45 minutes after ingesting 250 ml of liquid Drano® (9.5 percent NaOH). He had a history of substance abuse; one month previously, he was admitted to the hospital for depression with suicidal ideation. His primary complaints were a very sore throat and chest tightness. In the emergency unit, he vomited approximately 400 ml of blood. He was afebrile; his pulse was 85 beat/min and his blood pressure was 132/90 mmHg and stable. The remainder of the physical examination was unremarkable except for inflammation of the oropharynx with blister formation on the dorsum of the tongue. Serum electrolytes were normal, white blood count (WBC) was 13,000 cells/ml, and hematocrit was 47%. Chest and abdominal x-rays were normal with no free air patterns.

He was treated initially with an intravenous corticosteroid preparation and induced to drink milk that was associated with more vomiting. He subsequently was given nothing by mouth after transfer to the intensive care unit where intravenous H_2 blocker and antibiotic regimens were started. Barium swallow and endoscopy studies of the upper airway and gastrointestinal tract were performed; the studies showed the absence of peristalsis, diffuse gastric, and esophageal edema with areas of superficial denuded mucosa limited to the oropharynx. The vocal cords were mobile and nonedematous. The esophagus had second degree burns; the stomach had second-third degree burns. The duodenum was normal. A nasogastric (NG) tube with intermittent suction was used but enteric feedings were not given. No respiratory symptoms were present; repeated arterial blood gas determinations and spirometric tests of pulmonary function remained normal without evidence of aspiration. The patient continued to complain of pharyngitis associated with excessive salivation. The WBC increased to 32,000/ml with a fall to 18,000/ml by the end of the first week. At the beginning of the second week, he vomited approximately 400 ml of blood mixed with sloughs of mucosa on two occasions. A radionuclide aortogram showed no evidence of an aorto-esophageal fistula and treatment was limited

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Figure 1A. Barium study showing esophagel stricture.
Figure 1B. Barium study showing distal pyloric strictures.

to transfusion of packed red blood cells. On hospital day 22, the NG tube was removed, and when clear fluids were tolerated the diet was progressed to full liquids. The patient had no odynophagia or dysphagia. Two days later, he vomited; an upper gastrointestinal (GI) series was repeated demonstrating dilation of the proximal stomach and strictures of the lower third of the esophagus and distal stomach (Figures 1, 2, and 3). Esophagoscopy was performed and the endoscope could not pass the esophagus due to a stricture 32 cm from the incisors for which on hospital day 44, he began a series of endoscopic dilations. During week seven, a cardiopulmonary arrest occurred with successful resuscitation. A vasovagal episode secondary to vomiting and subsequent aspiration due to pyloric obstruction was postulated and gastrojejunostomy was performed in order to bypass the distal stricture of the stomach. Postoperatively with repeated esophageal dilations, the patient was started on a puree diet. Dilation subsequently was performed—three times weekly in order to alleviate symptoms of obstruction from the esophageal stricture. After discharge, he was electively dilated twice a month. Presently, four months post-bypass, he is tolerating a puree diet but has required more frequent esophageal dilations almost on a weekly basis. An upper GI series revealed the persistent esophageal stricture and patent gastrojejunostomy.



Figure 2. Barium study showing proximal gastric dilation.

DISCUSSION

The extent of tissue destruction from alkali is dependent on dose, as determined by concentration and volume ingested as well as the duration of individual tissue contact.[3] Stricture formation due to the ingestion of caustics can occur at any site from the oropharynx to the small bowel. The pathophysiology of this process of cicatrization is initiated by liquification necrosis, which in contrast to the coagulative necrosis resulting from acid ingestion penetrates into deeper tissues rendering surface irrigation ineffective. This is followed by an intense fibroblastic reaction and superficial granulation tissue formation that terminates with extensive scar formation and luminal narrowing. The process is ongoing with the phase of destruction determining principles of management.

ACUTE PHASE

The acute burn injury has been divided into inflammatory, edematous, and hemorrhagic phases all occurring within the initial few days following ingestion. Esophagoscopy and cinefluoroscopy are suggested during the first 12 to 48 hours to determine the extent of injury. Because of the great danger of perforation, the esophagoscope usually is advanced to but not through any severe burn area, particularly those that are narrowing or circumferential.[7] Over 50 percent of patients have serious esophageal injury present when vomiting, drooling, or stridor are present, whereas the presence of oropharyngeal burns alone is an unreliable indicator.[8,9] Endoscopy should be routine since the presence or absence of signs or symptoms cannot absolutely predict the presence or severity of gastroesophageal injury.[9-11]

Oral feeding may be maintained as tolerated[5,11,12] but for patients with severe injury who are unable to swallow, tube feeding or parenteral nutrition should be provided.[13] The benefit to the patient of enteric feeding through a NG tube has been maintained by some investigators to have therapeutic value in keeping the lumen of the esophagus open

in addition to its obvious nutritional role;[9,14] others use a more formal stent device.[15] Death during this initial period can occur from spontaneous perforation as well as mediastinitis, peritonitis, and pericarditis. Life-threatening hemorrhage can be precipitated by sloughing of necrotic mucosa tissues from the upper bowel or esophageal wall. Respiratory symptoms originating in the upper or lower airway may result from an initial or subsequent episode of aspiration. There is controversy over treatment during the acute phase of severe burns, some favoring the use of aggressive, early surgical intervention using an intraesophageal stenting procedure rather than waiting for stricture formation and the subsequent need for dilation.[15,16] If severe burns are present, immediate exploratory laparotomy is performed[15] and patients found to have full-thickness necrosis undergo, at celiotomy, primary gastrectomy and transhiatal esophagectomy[16-18] with reconstruction at a later date.[19-21]

LATENT PHASE

The esophageal wall is weakest during the period following the sloughs of necrotic tissue; the process of contracture of the underlying collagen fibers progresses at variable rates beginning during the first week and lasting as long as three to four weeks. Fistula formation between esophagus and tracheobronchial tree or aorta with their associated catastrophic complications can appear within days but are most characteristic during the second and third weeks of this phase of reaction.[22]

CHRONIC PHASE

The most serious long-term complication of caustic ingestion is stricture formation that can occur as early as the fourth week at any location in the esophagus, stomach, and small bowel. At this time, evaluation with barium is most valuable with subsequent studies done for comparison. As in our patient, the symptom-free intervals between bougienages shorten and esophagoplasty is required when dilation becomes futile or the threat of perforation too great.[13]

LATE PHASE

Cancer can occur in strictures between 13 to 71 years after the ingestion of lye.[23] The incidence of 0.8 to 4 percent has been estimated to be almost 1,000 times higher than in the normal population.[13]

THERAPEUTIC STRATEGIES

Treatment for the acute episode no longer involves attempts to dilute or neutralize the surface reaction because, as observed initially in this patient, it is not only ineffectual but likely to be complicated by aspiration due to acute obstruction from edematous



Figure 3. Barium study showing proximal gastric dilation and distal pyloric stricture.

occlusion of the esophageal lumen. Recently, sucralfate has been suggested.[24] Antacids potentially add to the burn injury as a result of the heat generated by the exothermic neutralization reaction and the phenomenon of internal regurgitation.[16] Similarly, in order not to re-expose the esophagus, neither the use of emetics nor gastric lavage should be pursued.

Antibiotics and corticosteroids remain the foundation for acute therapy as prophylaxis against infection and stricture formation.[2,3,5] Antibiotics are given empirically to avoid mediastinitis from early perforation or occult translocation.[25] The addition of corticosteroids has not been reported to alter the frequency and severity of stricture formation. Steroids, however, have been reported to increase the occurrence of perforation and infectious complications when given alone.[12]

The concept has been adopted that successful treatment is dependent upon the rapid and accurate assessment of both the location and severity of stricture formation.[27] Severity has been graded according to the luminal length involved and degree of narrowing as determined by the intensity (density) of the fibrotic process. Early panendoscopic[6,13,16,27] and radiologic criteria[4,27] have been described to make these evaluations. Esophograms should not be performed prior to or instead of esophagoscopy.[6] Others suggest only with celiotomy is it possible to determine the extent of injury.[17] To some degree, stricture formation essentially is a uniform occurrence,

generally at multiple sites; only rarely is there complete obliteration of the lumen. Stenosis is seen most frequently in the lower esophagus and obstruction of the gastric or pyloric area, while the least frequent site of severe stricture formation always is involved to some extent. This relative immunity from stenosis has been attributed to gastric acid neutralization of all but overwhelming volumes of the alkaline caustics. Pyloric obstruction characteristically appears within the first four weeks.

Acute obstruction always is a potential complication of the strictured lumen. Symptoms of impaction can be brought on by even too thick a barium preparation let alone a fruit pit, and aspiration pneumonia then may result. Over the long term, inanition and malignant degeneration rather than the corrosive perforation of the acute stages are the terminal sequence of events. The decision to undertake reconstructive surgery is determined by symptoms and the success or failure of subsequent bougienage to maintain patency. The frequency of bougienage, even if only for prophylaxis, is dictated by serial barium studies, nutritional state, and dysphagia. Self-bougienage has been advocated particularly for those who are poor surgical candidates.[28]

SUMMARY

The use of steroid and antibiotic prophylaxis no longer is tenable on the basis of recent studies showing their inability to favorably influence the outcome of caustic injuries. The need for early endoscopic and radiologic assessment if not gastroesophagectomy for severe injuries now is the management of choice. Further efforts to identify high-risk populations and efforts to educate them of the dangers must continue.[29] ■

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Complex Cystic Pelvic Mass

MARK T. DIMARCANGELO, DO
JAMES H. JACOBY, MD

The authors discuss computed tomography of a predominately cystic complex mass in the upper pelvis, detailing its classic roentgenologic features.

The patient is a 33-year-old white female with a palpable enlarged cervical lymph node. A subsequent biopsy revealed Hodgkin's lymphoma. The remainder of the history and physical examination was basically unremarkable. A computed tomography (CT) study was obtained to evaluate for mediastinal, retroperitoneal, and pelvic lymphadenopathy.

DISCUSSION

Figure 1 shows a mass comprised of a smooth, thin capsule (open arrow) surrounding internal components that are heterogeneous in density. In fact, there is a fat-fluid level (closed arrow) with the lower specific gravity fat (radiolucent substance) floating on the more radiodense fluid. Seeking a "middle ground" within this fat-fluid milieu is an ovoid heterogeneously dense structure that represents a hair ball (arrowhead). Figure 2, performed a few centimeters caudal to the image in Figure 1, demonstrates a calcific density (arrowhead) that has a bullet-like configuration indicating the presence of a tooth embedded in the fatty substrate. A CT image 1 cm below that of Figure 2 (not shown) demonstrated this mass to be situated along the right lateral aspect of the uterus.

Dermoid cysts that also are dubbed cystic teratomas are benign, usually asymptomatic tumors discovered serendipitously in young women undergoing imaging studies. Strictly speaking, the term teratoma should be reserved for a neoplasm incorporating all three germ cell layers, whereas a dermoid tumor should characterize an entity comprised only of ectodermal derivatives. Teratomas of

Dr. DiMarcangelo is affiliated with the Department of Diagnostic Radiology and Nuclear Medicine and Dr. Jacoby is acting chief, Department of Diagnostic Radiology and Nuclear Medicine, Cooper Hospital/University Medical Center, Camden. This paper was submitted in September 1990 and accepted in October 1990. Requests for reprints may be addressed to Dr. DiMarcangelo, Cooper Hospital/University Medical Center, Camden, NJ 08103.



Figure 1. CT image obtained at the inferior level of L5.



Figure 2. CT scan secured at the upper sacral region.

the ovary rarely degenerate into malignancy and may occur bilaterally up to 25 percent of cases.[1]

Plain film examination sometimes can suggest the presence of a dermoid cyst by revealing a preponderance of fat density and/or tooth-like calcifications in the pelvis. Ultrasound interrogation of the pelvis usually is the initial perspective of a cystic teratoma. Ultrasound usually reveals a mass containing high-level echoes reflecting the lipid and calcific components. In many instances, "the tip of the iceberg" sign prevails where the radiologist encounters acoustical shadowing casted by the dysmorphic teeth that results in obscuration of the remaining underlying soft tissue components.[2] On magnetic resonance imaging, the fat of these cysts will be hyperintense on T1-weighted pulse sequences as opposed to the teeth that will appear as areas of signal void. ■

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1991 MSNJ ANNUAL MEETING

The Board of Trustees of the Medical Society of New Jersey approved the Committee on Annual Meeting's recommendation that the 1991 Annual Meeting be held at the Trump Taj Mahal Casino Resort in Atlantic City, on Sunday, April 28, through Wednesday, May 1, 1991. Taj Mahal) for the 1991 Annual Meeting. (Housing Application on page 213) The daily schedule follows:

Saturday, April 27, 1991

3:30 p.m. Board of Trustees' Meeting

Sunday, April 28, 1991

8:00 a.m. Registration Opens
8:00 a.m. Message Center Opens
10:00 a.m. Educational Programs*
11:30 a.m. Exhibits Open
1:30 p.m. House of Delegates
3:30 p.m. Reference Committee Meetings

Monday, April 29, 1991

8:00 a.m. Registration Opens
8:00 a.m. Message Center Opens
8:30 a.m. Exhibits Open
9:00 a.m. House of Delegates (Election)
12:00 noon Golden Merit Award Ceremony and Reception
2:30 p.m. Reference Committee Meetings
5:00 p.m. JEMPAC Political Forum
5:45 p.m. JEMPAC Wine and Cheese Reception
6:30 p.m. Union County Medical Society Reception

Tuesday, April 30, 1991

8:00 a.m. Registration Opens
8:00 a.m. Message Center Opens
8:30 a.m. Exhibits Open
9:00 a.m. House of Delegates
1:30 p.m. House of Delegates
7:00 p.m. Inaugural Reception and Dinner honoring Doctor and Mrs. Joseph A. Riggs

Wednesday, May 1, 1991

8:00 a.m. Registration Opens
8:00 a.m. Message Center Opens
8:30 a.m. Educational Programs**
1:00 p.m. Board of Trustees' Meeting

*see Pages 210, 211
**see Page 212

Reporting of Physician Privileges and Malpractice Insurance Information to State and Federal Agencies

The National Practitioner Data Bank and the Professional Medical Conduct Reform Act of 1989

10:00 A.M., Sunday, April 28, 1991
Topaz Room, First Floor

The Health Care Quality Improvement Act of 1986 and the Professional Medical Conduct Reform Act of 1989 have mandated the reporting of malpractice settlements and verdicts, along with certain adverse privilege actions to the National Practitioner Data Bank and the State Board of Medical Examiners. Physicians have been understandably concerned about the impact of reporting such information to licensing and credentialling authorities. However, many have not had access to clear information on these reporting systems.

OBJECTIVES

Presentations by speakers from both reporting and receiving agencies will enable participants to:

- Understand the goals and objectives of these systems.
- Identify what events are reportable, and what data are reportable.
- Recognize the impact of these report mechanisms.
- Take actions necessary to protect their interests.

9:30 A.M. **Coffee and Registration**

10:00 **Welcome and Introduction**
James E. George, MD, JD, Moderator
Director, Department of Professional Liability Control
Medical Society of New Jersey

10:15 **The New Jersey View—Reporting and the State Board of Medical Examiners**
Michael B. Grossman, DO
President, New Jersey State Board of Medical Examiners

11:00 **The Federal Perspective—The National Practitioner Data Bank**
Adam P. Wilczek
Vice-President, Risk Prevention
Medical Inter-Insurance Exchange of New Jersey

11:30 **Panel Discussion**

12:00 **Adjournment**

Environmental Issues in New Jersey Medicine

Cosponsored by the Academy of Medicine of New Jersey and the Medical Society of New Jersey's Committee on Environmental Health

SUNDAY, APRIL 28, 1991
Tiara A, First Floor

Over the past two years, changes have occurred with the New Jersey State Department of Environmental Protection and the New Jersey State Department of Health dealing with two problem areas: the disposal of medical waste and questions arising from the extensive involvement with occupational medicine. Physicians now are responsible for keeping records on their disposition of medical waste and are accountable to the Department of Environmental Protection in this area. Violators face heavy fines and possible criminal penalties if waste is not treated properly. Right-to-know laws also are questioning a possible causal relationship between employee illness and the work environment.

OBJECTIVES

The practitioner will:

- know when to take an occupational/environmental history
- be aware of the practical components of an occupational/environmental history
- know the four World Health Organization categories of occupational disease
- be familiar with specific techniques for linking exposure to disease based on historical, laboratory, radiographic, pulmonary function, and other criteria
- be aware of resources for expert consultation in evaluation or complex occupational/environmental problems
- be aware of New Jersey's medical waste laws regarding solid waste management
- understand medical waste generator's specific responsibilities under today's regulations for management and disposal of regulated medical wastes

9:30 A.M.	**Registration**
10:00	**Welcome** Stanley R. Lane, MD, Chairman, MSNJ Committee on Environmental Health
10:05	**Practical Evaluation of Patient Concerns about Occupational and Environmental Problems** Howard M. Kipen, MD, MPH Assistant Professor, Department of Environmental and Community Medicine, UMDNJ-Robert Wood Johnson Medical School
11:05	**Questions**
11:25	**Break**
11:40	**Physicians Role in Complying with New Jersey's Medical Waste Regulations** Robert Confer Chief, Bureau of Special Waste Planning, Division of Solid Waste Management, New Jersey State Department of Environmental Protection Gary Sondermeyer Assistant Director, Policy and Planning, Division of Solid Waste Management, New Jersey State Department of Environmental Protection
12:40	**Questions**
12:55	**Summary and Adjournment** Stanley R. Lane, MD

THE ACADEMY OF MEDICINE OF NEW JERSEY designates this continuing medical education activity for 3 hours in Category I of the Physician's Recognition Award of the American Medical Association.

THE ACADEMY OF MEDICINE OF NEW JERSEY is accredited by the Accreditation Council for Continuing Medical Education to sponsor continuing medical education for physicians.

Changing Characteristics of HIV Infection

Cosponsored by the Academy of Medicine of New Jersey, the New Jersey State Department of Health, Division of AIDS Prevention and Control, and the Medical Society of New Jersey

WEDNESDAY, MAY 1, 1991
Tiara A, First Floor

Many of the widely held assumptions about prevention, diagnosis, and treatment of HIV infections need to be reassessed.

- The primary care physician now must consider the possibility of HIV infection in persons who are not members of the high-risk groups identified early in the epidemic. Women, children, and adolescents account for an increasing proportion of HIV infections, sometimes without having engaged in overtly high-risk behaviors.
- Clinical clues to suggest the diagnosis of HIV infection have become less reliable: *Pneumocystis carinii* pneumonia (PCP) and other illnesses that were characteristic of HIV infection early in the epidemic still occur, but a variety of other illnesses due to HIV infection occur with increasing frequency. Women and children have illnesses that often behave differently than illnesses in men; for example, and the natural history of HIV disease has been altered by the administration of zidovudine and PCP prophylaxis in early infection.
- Physicians and other health care workers (HCWs) also must consider the effects of HIV on their own practices since it is recognized that HIV may spread from patients to HCWs and from HCWs to their patients.

These changes require the clinician to reconsider strategies to identify, counsel, and test patients who are potentially infected and to modify the approaches used to prevent and treat HIV disease.

OBJECTIVES

Participants will be able to develop an effective case-management plan for HIV infection that can be implemented in their offices or clinics and will:

- recognize the role of antiviral and *Pneumocystis* prophylaxis in predisposing HIV-infected persons to new or atypical manifestations of HIV infection
- appreciate changing attitudes about counseling and testing for HIV infection and the underlying ethical and philosophical bases for those changes
- recognize unique patterns of infection in IV drug abusers, women, and children
- assess risks of transmission of HIV infection.

8:00 A.M.	**Registration & Coffee**
8:30	**Welcome** Dennis Quinlan, MD, Chairman, MSNJ AIDS Task Force
8:35	**New Concepts in Testing and Counseling for HIV Infection** John W. Sensakovic, MD, Ph.D. Physician Director, AMNJ AIDS PROGRAM Corporate Director of Medical Education, Cathedral Healthcare System Director of Nosocomial Disease Laboratory, St. Michael's Medical Center, Newark Associate Professor of Medicine and Infectious Disease, Seton Hall University School of Graduate Medical Education; Fellow, AMNJ
9:10	**Standardized Protocol for HIV Infections in Women and Children** James M. Oleske, MD, MPH Francois-Xavier Bagnoud Professor of Pediatrics Director, Allergy, Immunology & Infectious Diseases, UMDNJ-New Jersey Medical School; Medical Director, Children's Hospital AIDS Program at United Hospitals of NJ, Newark; Fellow, AMNJ
9:45	**Break**
10:00	**HIV Infection in the Health Care Setting** Richard E. Dixon, MD, Conference Chairman Medical Director, Helene Fuld Medical Center, Trenton Associate Professor of Medicine, Hahnemann University School of Medicine; Fellow, AMNJ
10:35	**Panel Discussion**
11:30	**Adjournment**

PREREGISTRATION REQUIRED

- THE ACADEMY OF MEDICINE OF NEW JERSEY designates this continuing medical education activity for 3 hours in Category I of the Physician's Recognition Award of the American Medical Association
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This program will be repeated on May 7, 1991 (Sheraton Newark Airport, Elizabeth, NJ) and May 21, 1991 (Sheraton Poste Inn, Cherry Hill, NJ). Call Margo Churchwell, AMNJ, 609/896-0486 for registration. Gerald H. Friedland, MD, Co-Director/AIDS Center, Montefiore Medical Center, will be the keynote speaker at the May 7 and May 21 events.

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NOTEBOOK

TRUSTEES' MINUTES

A regular meeting of the Board of Trustees was held on January 13, 1991, at executive offices in Lawrenceville. Detailed minutes are on file with the secretary of your county society; a summary of significant actions follows.

Report of the President . . . Will obtain a list of New Jersey physicians who are nonmembers of the AMA in an effort to increase AMA membership and prevent the loss of delegate allocation.

Report of Executive Director . . .
(1) MSNJ Membership . . . Provided membership status report as of December 31, 1990.
(2) Federal Budget for Fiscal Year 1991 . . . Received a report from the AMA Division of Legislative Activities identifying projected federal budget activities for 1992.
(3) Litigation . . . Noted the following: no decision has been rendered in the medical malpractice surcharge case; after Judge Lasser ruled against MSNJ on the $100 no-fault fee tax, the Society filed a notice of appeal; and State Board of Medical Examiners adopted the rule to authorize physician assistants in New Jersey.
(4) Legislation . . . Noted the following bills: A-743 (optometric drug bill that would authorize optometrists to diagnose disease and prescribe drugs) fell one vote short for approval; and A-3042 (Medicare assignment) and A-4367 (uncompensated care) are being linked together by Governor Florio while MSNJ presses not to have the issues linked together.
(5) Third-Party Payor Nonphysician Reviewers . . . Will reissue a letter to the State Board of Medical Examiners seeking either legislation or regulation to prevent third-party payors from using nonphysician personnel to make medical decisions relating to insurance reimbursement.

AMA Interim Meeting . . .
(1) General Information . . . Noted the following from Dr. Karl Franzoni, chairman of the AMA delegation: AMA has finalized measures designed to prevent recurrence of fiscal irregularities; possible delegate loss for New Jersey due to membership; appeal for increase political activism; and AMA encourages every physician to make a commitment to attempt to eliminate drug abuse by the year 2000.
(2) New Jersey Resolutions . . . Noted the following from Dr. Franzoni from the AMA Interim Meeting:
(a) Lift Chair—Medicare Reimbursement . . . Noted the AMA House adopted a substitute resolution resolving that the AMA monitor and assist physicians and patients during implementation of provisions of the Omnibus Budget Reconciliation Act of 1990; that limit Medicare payment for seat lift chairs to the seat lift mechanism only and not the chair; and that forbid durable medical equipment suppliers from providing physicians or Medicare beneficiaries with completed or partially completed documentation of medical necessity.
(b) Resignation of Health and Human Services Inspector General Kusserow . . . Noted the AMA House adopted a substitute resolution to continue efforts to seek Richard Kusserow's resignation or dismissal and encourage state medical societies, national medical specialty organizations, auxiliaries, and physicians to write to President Bush, Doctor Sullivan, and congressmen to support the AMA action.
(c) HCFA Precertification for Emergency Surgery . . . Noted the AMA House approved the following substitute resolution:

> Blanket preadmission review of all or the majority of hospital admissions does not improve the quality of care and should not be mandated by the government, other payors, or hospitals. Policies for review should be established by state or local physician review committees and the actual review should be performed by physicians, or under the close supervision of physicians. All preadmission review programs should provide for immediate hospitalization, without prior authorization or subsequent denial of payment based on lack of such authorization, of any patient whose treating physician determines the admission to be of an emergency nature.

(d) Physician Notification Under PRO Review . . . Noted the action called for in the New Jersey resolution was accomplished.
(e) Lack of PRO Cost Effectiveness . . . Noted that the resolution (asking for a re-evaluation of the work of PRO, on the basis of cost effectiveness) was adopted on the consent calendar.
(f) National Practitioner Data Bank: Adverse Applicant Infor-

mation and Response Time . . . Noted the delegates voted to ask the AMA for the following:

To continue to work with the Department of Health and Human Services to ensure that the Data Bank does not collect nor release information regarding denial of specific clinical privileges based solely on failure to meet hospital-established minimal criteria not related to a physician's competence or professional conduct; to continue to work with HHS to revise the Bank dispute process to accelerate a physician's opportunity to attach an explanation or statement to a disputed report; to work with HHS to establish an appropriate response time for hospital inquiries to the Data Bank; to work with HHS to establish a mechanism to inform physicians when an inquiry to the Bank has been made; to reaffirm its policy that reports should be purged after five years; to support efforts to require the same Data Bank reporting requirements for physicians, dentists, and other licensed health care practitioners; to reaffirm its policy and use all necessary efforts to direct the Data Bank to send all notifications to physicians by certified mail, return receipt requested; and to use all efforts at the federal level to direct the Data Bank to begin the 60-day appeal process from the date the physician receives notification.

Committee on Graduates of Non-U.S. Medical Schools . . . Approved the following recommendations:

That the Medical Society of New Jersey support the use of a common examination and grading system from foreign and U.S. medical school graduates.

That the name of the Committee on Graduates of Non-U.S. Medical Schools be changed to the Committee on International Medical Graduates.

New Business . . . Noted that MSNJ will continue to oppose the certificate of need. □

UMDNJ NOTES

Cancer Institute Gains $10.5 Million for Development. The Cancer Institute of New Jersey, seeking ultimately to win federal designation as a comprehensive cancer center, has secured $10.5 million in funding from government and industry. The funds will be used to build a new research facility and recruit a medical director of national stature.

William R. Walsh Jr., board chairman of New Brunswick Affiliated Hospitals (NBAH) and former executive vice-president and treasurer of the Robert Wood Johnson Foundation, will chair the Institute's development efforts to raise the additional funds.

The Institute—the first and only such multidisciplinary, medical school-based center in New Jersey—is a joint venture of UMDNJ and NBAH. NBAH comprises Robert Wood Johnson University Hospital, core teaching hospital of UMDNJ-Robert Wood Johnson Medical School, and St. Peter's Medical Center, a major teaching affiliate.

Scientists Measure Effects of Manipulation Therapy. In research at UMDNJ and Rutgers University, biomechanical engineers have measured and demonstrated what osteopathic physicians have substantiated clinically for 100 years: Osteopathic manipulation therapy (OMT) is effective in treating pain in the musculoskeletal system. OMT is a therapeutic technique involving the manual movement of muscles and joints.

In research at UMDNJ-School of Osteopathic Medicine, based in Stratford, scientists combined bioengineering techniques with traditional diagnostic methods to measure the changes in human tissue that result in pain and other symptoms. Twenty-five back pain patients and a control group of 25 medical students participated in the study.

The research program was led by Dr. Charles Steiner, professor and chairman of osteopathic sciences at the osteopathic medical school. Dr. Steiner, who presented his findings at the annual meeting of the American Osteopathic Association, said that bioengineering methods were key to gaining measurements to demonstrate tangible muscle changes.

Laser System Clears Coronary Arteries. An obstructed coronary artery of a 62-year-old patient was cleared by a new laser system used for the first time in New Jersey by UMDNJ physicians at Robert Wood Johnson University Hospital, New Brunswick. The procedure, using the excimer laser angioplasty system, was performed by Dr. Jai Agarwal, director of interventional cardiology and associate professor of medicine at the UMDNJ-Robert Wood Johnson Medical School. He performed the laser angioplasty on a patient who returned home 2 days later.

In the new procedure, a cool ultraviolet laser beam vaporizes plaque that causes arterial blockages in the cardiovascular system. The laser system has been developed as a nonsurgical treatment that can be used in cases where balloon angioplasty cannot help. In balloon angioplasty, a balloon at the tip of a catheter is inflated in the problem area to push plaque against the arterial walls.

Lead Poisoning Found in Suburban Youngsters. Lead poisoning, associated mainly with inner-city youngsters, also is being diagnosed in New Jersey children from surburban families. While inner-city children remain at highest risk, youngsters from the surburbs and even rural areas also are affected.

The spread of the lead problem to the suburbs is reported by Dr. Antonia Ty, director of UMDNJ's Pediatric Lead Poisoning Program in Newark. She noted that middle-class parents usually are unaware of the possibility of lead toxicity and their doctors do not normally test for it because they do not think in those terms.

To both educate parents and

treat children, a consortium of three Newark facilities was formed in 1975 to coordinate the Pediatric Lead Poison Program. All children who attend a clinic or who are admitted to a consortium hospital are tested for lead. Once a youngster is identified as having lead poisoning, the child is followed at intervals as variable as twice weekly to monthly, depending on need. The New Jersey Lead Consortium comprises UMDNJ-University Hospital; Children's Hospital of New Jersey, a unit of United Hospitals Medical Center; and Newark Beth Israel Medical Center.

Haitian-Creole Translator Joins Genetics Unit. A Haitian-Creole-speaking assistant has joined the roster of translators in the Division of Human Genetics at UMDNJ-New Jersey Medical School.

Haitian communities have developed in Newark, Elizabeth, the Oranges, and Irvington.

The Division of Genetics also is working with other groups such as Spanish- and Portuguese-speaking families, to enhance their understanding and use of genetic services. The division makes presentations to health providers, community groups, and agencies to inform them about the early detection and prevention of birth defects and genetic disorders. □

MSNJ AUXILIARY

In January, state and county Auxiliary members were urged to contact New Jersey legislators to voice opposition to mandatory Medicare assignment. In addition, Auxiliary members from Passaic, Bergen, Union, and Essex Counties joined and supported Medical Society members attending the Assembly Senior Citizens Committee public meeting held at the West Orange Municipal Building. The meeting was scheduled to air pending Medicare assignment legislation (A-3042 and A-4367) that Auxiliary members across the state of New Jersey are working vigorously to defeat.

Individual county auxiliaries continue to promote good will in their communities through a variety of health-related activities.

Burlington County raised funds for the Community Nursing Services of the Memorial Hospital of Burlington County—a facility that provides services to patients (especially elderly) who previously were admitted to the hospital.

Camden County sponsored a Women's Awareness Day on March 16, and Cape May County held a "Ball" on March 9 to benefit its nursing scholarship program.

Essex County has a drive underway to encourage members and friends to get annual check-ups, including mammograms. Auxiliary members also met with Assemblywoman Marion Crecco to discuss medical-related issues such as testing for AIDS among prisoners and seat belt use in school buses. Many Auxiliary members sponsored a group of volunteers from UMDNJ-Newark who participated in a walkathon designed to draw attention to the needs of females and children suffering from AIDS.

In Gloucester County, the Auxiliary participated in the Underwood-Memorial Hospital Health Fair at the Deptford Mall on January 26. Volunteers distributed medi-file cards and disseminated information on seatbelts, infant car seats, steroid abuse, and staying active after 60.

Morris County donated $1,000 to purchase "wish list" items for the pediatric wards of the county's three hospitals. In addition, when the Morris County Medical Society redecorated its offices in Morristown, the Auxiliary donated vertical blinds as a big "thank you" for all the help the physicians and staff have given them in the Auxiliary's reorganization years.

Ocean County raised $2,500 for the American Medical Association Education and Research Foundation—all from its "Holiday Sharing Card."

Salem County raised almost

ARE YOU MOVING?

If so, please send a change of address to *NEW JERSEY MEDICINE,* Medical Society of New Jersey, Two Princess Road, Lawrenceville, NJ 08648, at least six weeks before you move.

Name_____

Old Address_____

City_____ State_____ Zip_____

New Address_____

City_____ State_____ Zip_____

$5,000 from its "Mistletoe Ball," held yearly to benefit its Gertrud Jonas Nursing Scholarship program. Salem Auxiliary members also donated clothing and gifts to the Crisis Center for battered women and wrote holiday cards for nursing patients unable to do so themselves. Recently, members distributed 2,400 copies of the Bill of Rights to Salem County schools and sent 100 copies to the Soviet Union.

The Union County Auxiliary collected and donated food items, toiletries, clothing, small appliances, and baby items such as swings and strollers to the battered women's shelter in Elizabeth. Auxiliary members also played Santa Claus to the hospitalized children at Elizabeth General Medical Center pediatrics department by donating new toys and lots of good will. □ Marion Geib

LEGISLATIVE BULLETIN

The accompanying list presents, for your information and reference, the official position of the Medical Society of New Jersey regarding bills currently in the Legislature. As further bills of medical interest are introduced, they will be considered by the Society and supplemental bulletins will be supplied, indicating the Society's position.

The Society has adopted the following regular range of official positions concerning proposed legislation:

Active Support: All-out support for the measure.

Active Opposition: All-out opposition for the measure.

Conditional Approval: To indicate that the approval of the Society is conditional, subject to elimination of the unsatisfactory elements of the bill that are pointed out.

Approval: Commended as satisfactory, but not actively supported.

Disapproval: Rejected as unsatisfactory, but not actively opposed.

No Action: Considered, but not regarded as significant or relevant to the proper interest of the Society.

Senate/Assembly (Active)

S-2546-Lynch—Contact Lens Dispensing. Provides for the regulation and certification of contact lens dispensers by the Board of Ophthalmic Dispensers and Technicians. **Disapproved, with Active Opposition if the bill moves,** the fitting of contact lenses exposes patients to certain eye injuries. The task, therefore, requires the care, skill, and experience of optometrists and physicians.

S-2583-Feldman—Social Workers. Licenses the practice of social workers and includes the diagnosis and treatment of mental and emotional disorders and the use of psychotherapy. **Active Opposition,** there has been no demonstrative need for licensure of this occupation as a separate and independent profession.

S-2605-DiFrancesco—Occupational Therapy. Provides for the regulation and licensing of occupational therapists and occupational therapy assistants. **Active Opposition,** there is no demonstrated public health need to create a licensed professional in occupational therapy. Currently, physical therapists and nurses are meeting the needs of this legislation.

S-2607-Codey—Licensure/Burden of Proof. Raises the standard of proof in medical and podiatry disciplinary proceedings to "clear and convincing." **Active Support.**

S-2637-Dalton—Structured Verdicts. Provides for structured verdicts when future damages exceed $250,000. **Active Support.**

S-2648-Girgenti—County Ombudsman. Creates a county ombudsman system to serve as an investigational and enforcement arm of the State Office of the Ombudsman for the Institutionalized Elderly. It would be up to each county to decide whether to participate. The state would reimburse one-half the operating expenses. **Active Opposition,** the current state office of the ombudsman produces an extensive, counterproductive, and expensive overlapping of the New Jersey State Department of Health, the State Board of Medical Examiners, and the Office of the Public Advocate. Creation of county units would generate fiscal and operational chaos.

S-2663-Van Wagner—Nurse Midwives/Prescriptions. Permits nurse midwives to prescribe drugs as delineated in standing orders and practice protocols developed with a collaborative physician. The nurse must receive the approval of the State Board of Medical Examiners to participate in prescribing activity. **Active Opposition,** nurses are not qualified to make a medical diagnosis nor to prescribe therapeutic medications.

S-2704-Paterniti—Orthotists and Prosthetists. Provides for the licensing of orthotists and prosthetists by the Division of Consumer Affairs. A nine-member advisory committee would assist the director. Two of the nine members would be physicians. **Active Opposition,** there has not been a demonstrated need to license this practice as a profession.

S-2751-Cardinale—Physical Therapy Assistants. Provides that a physical therapy assistant may be employed by a physician, podiatrist, or chiropractor to administer ultraviolet and electromagnetic rays, deep heating agents, diathermy, and ultrasound. **Active Support.**

S-2789-Lesniak—Respiratory Care. Provides for the licensing of respiratory therapists who are to function under the direction or supervision of a physician. **Active Opposition,** there is no need to separately register and license these therapists since they are functioning well under existing laws.

S-3494-Zane—Unemployment. Exempts physicians acting as independent contractors from being subject to unemployment compensation and temporary disability contributions. **Active Support.**

A-2811-Doria—Optometry. Amends the optometric act to repeal that section that prohibits optometrists from practicing medicine. **Active Opposition,** optometrists are not medical doctors and, therefore, should not be given the mandate, via legislation, to prescribe and to administer drugs.

A-3001-Doria—Optometry. Same as **A-2811** except it has a revised statement. **Active Opposition,** (same as **A-2811**).

A-3331-Ford—Wrongful Death. Makes various changes in the wrongful death act including expansion of recoverable damages. **Active Opposition,** this legislation will increase professional liability costs. It also will impact on other areas of liability, i.e. automobile liability, product liability.

A-3355-Bryant—Structured Verdicts. Provides for structured verdicts when future damages exceed $250,000. **Active Support.**

A-3359-Kavanaugh—Triplicate Prescriptions. Requires that all schedule II prescriptions be written on state-issued triplicate forms. **Active Opposition,** these systems have been attempted elsewhere and are not regulatory effective nor efficient.

A-3434-Deverin—Occupational Therapists. Provides for the licensing and regulation of occupational therapy. **Active Opposition,** there is no demonstrated public health need to create a licensed professional in occupational therapy. Currently, physical therapists and nurses are meeting the needs of this legislation.

A-3529-Impreveduto—Health Licensing. Provides that no new category of health practitioners shall be authorized without legislative approval. **Active Support.**

A-3531-Impreveduto—Nurse Midwives. Authorizes nurse midwives who have registered with the State Board of Medical Examiners to write prescriptions consistent with protocols established by their collaborative physician. **Active Opposition,** nurses are not qualified to make medical diagnosis nor to prescribe therapeutic medications.

A-3640-Cohen—Social Work. Licenses social workers and permits them to engage in diagnosis and treatment of mental disorders and to engage in psychotherapy. **Active Opposition,** there has been no demonstrative need for licensure of this occupation as a separate and independent profession.

A-4057-Zangari—Worker's Compensation. Permits injured employees to select the physician or chiropractor of their choice if their employer provides a list of approved practitioners. **Active Opposition,** today there are many various health care delivery systems—HMOs, PPOs, etc.—that employers purchase and these systems define providers by policy. (It was recommended that MSNJ meet with New Jersey Chamber of Commerce in an effort to create proposed legislation that might lead to a more prudent and more financially responsible program of worker's compensation in the state of New Jersey.)

A-4090-Bryant—Physical Therapy Services. Provides that a physical therapist may treat a patient without physician referral. **Active Opposition,** this legislation is an incursion into the practice of medicine and would allow physical therapists to examine and treat patients without physician direction and would expose patients to delays in diagnosis, misdiagnosis, and iatrogenic injuries.

Senate/Assembly (Monitor)

S-163-Graves—AIDS. Concerns testing of persons arrested or convicted of certain crimes for AIDS. **Approved.**

S-371-Van Wagner—Home Health Care. This bill establishes an 18-month home health and community care demonstration program in the Department of Human Services. This program is designed to provide for the delivery of community-based home health care services by local home health and community care demonstration centers to functionally impaired persons who are at least 65 years of age or older or who are disabled pursuant to the Social Security Act. **Disapproved,** the monies to be spent on this program would be better spent on current services.

S-395-Van Wagner—New Jersey Health Insurance Risk Sharing Plan. Creates New Jersey Health Insurance Risk Sharing Plan. **No Action.**

S-644-Ewing—HIV Testing of Newborns. Requires that all newborns be tested for HIV sensitivity. **Approved.**

S-804-Rice—AIDS. Requires hospitals to accept a fair share of AIDS patients. **Action Deferred,** pending further information from the New Jersey Hospital Association.

S-871-Rice—AIDS. Requires persons convicted of certain drug offenses to be tested for AIDS. **Disapproved,** bill should be reworded to encompass screening all prisoners for AIDS.

S-885-Rice—Sickle Cell Anemia/Newborns. Provides for detection and treatment of sickle cell anemia in newborn children—appropriates $375,000. **Approved.**

S-1211-Ambrosio—Advance Directives for Health Care. Establishes procedures by which patients may execute advance directives for their care if they became incapable of making their own treatment decisions. **Approved.**

S-1444-Bassano—AIDS. Establishes the New Jersey AIDS and Viral Disease Tissue Research Bank—appropriates $30,000. **Disapproved,** this bill is counterproductive and would lower a nationally recognized standard testing basis.

S-1445-Bassano—Lyme Disease. The Lyme Disease Prevention and Control Act. **Approved.**

S-1698-Dorsey—EMT. Permits certain rescue squad members to be certified as emergency medical technicians and prohibits their exclusion from instruction. **Disapproved,** this bill is counterproductive and would lower a nationally recognized standard testing basis.

S-1709-Dorsey—EMT. Permits physicians and surgeons to use emergency warning lights. **No Action.**

S-2282-Bassano—Anabolic Steroids. Classifies anabolic steroids as a "Schedule V" drug. **Action Deferred,** pending further clarification from the Commissioner of Health concerning its six-month mandate to decide the merits of including anabolic steroids in the Controlled Substance Act.

S-2358-Costa—Surrogate Contracts. Provides requirements for surrogate gestation contracts. **Disapproved,** this legislation violates public policy.

S-2421-Dalton—Worker's Compensation. Applies the concept of "delayed discovery" to the statute of limitations in worker's compensation matters. **No Action.**

S-2446-Van Wagner—Caller ID Blocks. Requires the Board of Public Utilities to mandate that telephone carriers provide blocking services to holders of unpublished numbers at no extra charge. **Approved.**

S-2536-Rand—Dialysis Technicians. Permits the Board of Nursing to certify and regulate the practice of dialysis technicians. **Approved.**

S-2559-Paterniti—Organ Donor Study Commission. Provides for an organ donor study commission. Two of the members would be ex-officio. Seven members would be nominated by the New Jersey Hospital Associa-

tion to the governor. **Disapproved,** unnecessary legislation—organ donor program already in effect.

S-2654-Paterniti—Podiatry. Permits podiatrists to certify disability for the purpose of issuing handicapped license plates. **No Action.**

S-2691-Paterniti—Uncompensated Care. Provides for documented fact finding by hospitals before reimbursement for uncompensated care is permitted. **No Action, same as A-3403/LAW c.88 P.L.1990.**

S-2853-McManimon—Parental Notification for Abortion. Requires parental notification before abortion performed on pregnant minor or incompetent female. **Disapproved,** this legislation would interfere with the physician/patient relationship and drive young women to seek illegal abortions.

S-2854-Lipman—Consent (HIV Testing). Requires written consent to HIV sensitivity testing. **Disapproved, with Active Opposition if the bill moves,** MSNJ is opposed to mandatory HIV testing.

S-2918-McNamara—New Jersey Medical Malpractice Reinsurance Association. Exempts certain medical professionals, hospitals, and HMOs from surcharges to pay the deficit of the New Jersey Medical Malpractice Reinsurance Association and requires surcharges based on loss experience. **Conditional Approval, pending further amendments to the bill.**

S-2933-Ewing—HIV Testing Persons Charged with Crimes. Requires that persons charged with crimes shall undergo HIV testing whenever they have exchanged body fluids with law enforcement officers, victims, or others. **Approved.**

S-3034-Zane—HIV Testing (Marriage License). Requires HIV testing before issuance of a marriage license. **Action Deferred,** pending further information from MSNJ's Council on Public Health.

S-3053-Dalton—Blood Transfusion (same as A-4082). This bill establishes the "Blood Safety Act of 1990." The bill requires that if a blood transfusion is likely to be necessary during surgery, a physician or surgeon must inform his patient of blood transfusion options, that is autologous, designated, and homologous blood transfusions. The physician or surgeon then would note on the patient's medical record that all blood transfusion options have been explained to the patient prior to surgery. **Action Deferred,** infringement on the practice of medicine—services already being done as standard of good medical practice. Further information is being requested from the New Jersey Society of Pathologists, the New Jersey Chapter, American College of Surgeons, and the blood banks.

A-24-Kavanaugh—Surrogate Agreements. Prohibits surrogate parenting agreements for consideration as crime of the third degree. **No Action.**

A-337-Deverin—Medicaid. Broadens the scope of Medicaid eligibility. **Approved.**

A-740-Roberts—Mobile Intensive Care Services. The Mobile Intensive Care Services Support Act—appropriates $8,000,000. **Action Deferred,** pending further discussion by the Committee on Emergency Medical Care.

A-785-Roma—Mammograms/Insurance Coverage. Requires health insurers to provide coverage for mammograms, pap smears, and infertility tests. **Approved.**

A-793-Roma—Boating While Intoxicated Statute. Establishes additional enforcement measures to monitor sentences imposed on drunk boaters; establishes two-day jail term for sentence violations. **Approved.**

A-971-Cohen—AIDS. Makes knowing transmittal of AIDS a third-degree crime. **Conditional Approval,** the bill is legally malconstructed since the legal and medical portions of the bill are in error.

A-1191-Cooper—Death with Dignity Act. Approved.

A-1341-Bryant—Right to Die Act. Approved.

A-1413-Kamin—New Jersey Declaration of Death Act. Approved.

A-1418-Kamin—Defibrillation/EMT. Permits certain persons to perform defibrillation. **Action Deferred,** pending further discussion by Committee on Emergency Medical Care.

A-1456-Pelly—CPR Instruction. Requires instruction in cardiopulmonary resuscitation to each secondary school pupil. **Approved.**

A-1680-Albohn—Emergency Warning Lights. Permits physicians and surgeons to use emergency warning lights. **No Action.**

A-1768-McEnroe—DOH/Midwife Prenatal Program. Requires commissioner of health to establish a nurse-midwife prenatal demonstration program. **Disapproved,** this bill is not clear in its intent and what it hopes to accomplish.

A-2139-Rocco—Fetal Tissue. Requires that fetal remains be examined by a pathologist who shall report findings to the referring physician. Remains not disposed of by interment shall be incinerated pursuant to the New Jersey State Department of Health regulation. **Conditional Approval,** pending deletion of item #3 from the bill.

A-2270-Farragher—Parental Notification/Abortion. Requires physicians to notify, in writing, the parents of unemancipated minors (less than 18) 72 hours prior to an abortion. **Disapproved,** this legislation would interfere with the physician/patient relationship and drive young women to seek illegal abortions.

A-2278-Arnone—Emergency Medical Care. Establishes registration system for medical transporter vehicles. **Action Deferred,** pending further discussion by the Committee on Emergency Medical Care.

A-2466-Randall—Medical Power of Attorney. Approved.

A-2467-Randall—Withdrawing/Withholding Life-Sustaining Treatment. Provides for withholding of life-sustaining treatment in absence of medical directive or power of attorney. **No Action.**

A-2492-Randall—New Jersey Health Care Directives Act. Approved.

A-2494-Randall—Fetal Alcohol Syndrome (FAS). Requires sellers of alcoholic beverages to publish a warning regarding FAS. **Approved.**

A-2496-Randall—Tobacco Warnings. Requires sellers of tobacco to post signs warning of the hazards of smoking during pregnancy. **Approved.**

A-2503-Randall—Hospital Records. Requires the commissioner of health to set fees for the copying of hospital records. **No Action.**

A-2514-Randall—New Jersey Health Care Directives Act. Approved.

A-2554-Mattison—AIDS/ARC. Requires hospitals to accept fair share of AIDS/ARC patients. **Disapproved,** it is unnecessary and unworkable. In-

centives, not mandates, should be given to hospitals to accept their fair share of AIDS patients. The New Jersey State Department of Health is setting up programs to assure that no hospital is overburdened with AIDS patients.

A-2613-Naples—School Buses/ Seat Belts. Requires school buses to be equipped with seat belts. **Approved.**

A-2639-LoBiondo—Health Needs Study. Requires the commissioner of health to conduct a study of the health needs of low-income persons over the age of 60. **No Action.**

A-2676-Martin—Central Registry/ Head Injuries. Requires physicians and hospitals to report patients with head injuries to the New Jersey State Department of Health. **Disapproved,** unworkable legislation—the number of cases would be infinite due to the various types of injuries that would fall within the overly broad system.

A-2699-Martin—Drug Testing/ Athletes. Requires high school athletes to be tested for drug abuse. **Disapproved,** because of the lack of confidentiality in the bill.

A-2719-Martin—Organ Donation. Directs the Division of Motor Vehicles to redesign the driver's license so that the organ donation form is a part of it. **No Action.**

A-2800-Littell—Health Care Costs. Creates a commission to study the impact of health care costs on employee benefit programs. No physician representation is provided. **No Action.**

A-2801-Littell—Emergency Medical Care. Prohibits formation of local, regional, or statewide emergency medical service coordinating areas. **Disapproved,** this bill would be in conflict with the statewide 911 system.

A-2876-Doyle—Civil Immunity and Disclosure. Requires the reporting of certain potentially violent patients to the police and grants immunity therefore. **Approved.**

A-2878-McEnroe—Organ Transplants. Creates an organ transplant fund and advisory council. **Approved.**

A-2914-Moran—Podiatry. Declares that podiatrists are "physicians" within the scope of their licensing act. **Disapproved,** because the wording of such legislation would mislead the public into assuming "podiatrists" are fully licensed physicians. If the intent of this bill relates to insurance reimbursement, it should be drafted to change the insurance code. (It was recommended that MSNJ look into previous legislation that usurped the use of the word "physician.")

A-2957-Kronick—Natural Death Act. No Action.

A-2984-Foy—Notification/Agent Orange. Requires physicians who treat veterans who may have been exposed to Agent Orange to file a report with the New Jersey State Department of Health if the veteran so consents. **Action Deferred,** pending further information from the Council on Public Health.

A-2999-Rooney—Fertility Drugs/ Consent. Provides for statutory informed consent related to the administration of fertility drugs. **Disapproved,** infringement on the private practice of medicine.

A-3004-Colburn—DRG. Calls for a DRG study commission. **Approved.**

A-3088-Colburn—Medicaid. Expands Medicaid coverage eligibility for pregnant women to 185 percent of the federal poverty level. **Approved.**

A-3199-Spadoro—Egg Labeling/ Public Health. Imposes labeling and identification requirements for the packaging and marketing of eggs and egg-producing poultry for epidemiological purposes. **Approved.**

A-3256-McGreevey—Health Insurance/Drug Abuse. Mandates coverage of treatment for drug abuse as eligible for reimbursement by health insurers. **Approved.**

A-3280-Cimino—Audiologists/Insurance Benefits. Provides that audiologist services are reimbursable under health insurance contracts. **Approved.**

A-3281-Felice—Medicaid/Vaccines. Provides that practitioners can receive at no cost immunization vaccines from the Department of Health to be used for Medicaid patients. **Approved.**

A-3353-Randall—Caller ID. Limits caller ID availability to residential customers, public safety agencies, and hospitals. **No Action.**

A-3368-Farragher—School Health Services/Abortion. Prohibits school health services from dispensing contraceptives and abortifacients, making referrals for abortion, or providing abortion counseling. **No Action.**

A-3389-Bryant—Prescriptions. Requires that prescription benefits in the State Health Benefits Program (state employees) shall apply equally to local pharmacies and any mail-service program. **Conditional Approval,** pending amendment requiring that the mail-service programs adhere to the standards of the New Jersey pharmaceutical laws.

A-3568-Colburn—Bone Marrow Transplants. Requires that hospitals be reasonably reimbursed for bone marrow transplants. **Approved.**

A-3653-Mazur—Draize Test. Prohibits the use of the Draize test after January 1992 and places severe limitations prior to that time. **Disapproved,** the use of research animals is necessary to protect the public and advance scientific study.

A-3664-Penn—Health Care Facilities/Psychologists. Provides that health care facilities must grant privileges to psychologists. **Disapproved,** psychological services do not meet the severity of illness and intensity of service standards of acute care hospitals.

A-3732-Naples—School Buses. Requires certain seat height and seat belts on school buses; requires use of seat belts on school buses. **Approved.**

A-3800-Pelly—Health Insurance. Requires health insurers to provide coverage for preventive health services, places a cap on the amount of liability therefore, and provides for an annual adjustment based on the Consumer Price Index **Approved.**

A-3829-Bryant—Abused Children. Expands definition of abused child to include drug addicted infants and children of drug abusing parent or guardian. **Approved.**

A-4022-Bush—HIV Testing of Newborns. Requires newborns to be tested for the HIV sensitivity unless the parents express a written objection. **Approved.**

A-4023-Bush—Newborn Testing. Provides all newborns shall be tested for the presence of controlled dangerous substances unless the parents object based upon religious belief. **Approved.**

A-4082-Roberts—Blood Transfusions (same as S-3053). This bill establishes the "Blood Safety Act of 1990." The bill requires that if a blood transfusion is likely to be necessary during surgery, a physician or surgeon must inform his patient of blood transfusion options, that is autologous, designated, and homologous blood trans-

fusions. The physician or surgeon then would note on the patient's medical record that all blood transfusion options have been explained to the patient prior to surgery. **Action Deferred,** infringement on the practice of medicine—services already being done as standard of good medical practice. Further information is being requested from the New Jersey Society of Pathologists, the New Jersey Chapter, American College of Surgeons, and the blood banks.

MSNJ HEALTH CARE PROGRAMS

Jean Wasielczyk has become an expert on personal health care insurance plans for New Jersey physicians. As an assistant vice-president at Donald F. Smith & Associates, she has been responsible for administering the Medical Society of New Jersey-sponsored health care insurance plans for over 15 years. She has found that while superior contractual provisions and a higher level of benefits are important, service is the key to the success of MSNJ programs.

Ms. Wasielczyk and her staff of representatives at the Lawrenceville-based insurance consulting and brokerage firm handle the billing, enrollment, and claim inquiries for the more than 4,000 member physicians who participate in the sponsored health care plans. Each staff member works exclusively on the MSNJ group account and they understand the benefit provisions and administrative procedures in considerable detail.

The most valuable service provided by the staff of Donald F. Smith & Associates is professional assistance with participating members' claims. Instead of calling Blue Cross/Blue Shield directly, and speaking with a different person each time, participating physicians and their covered employees may simply contact MSNJ service representatives. Ms. Wasielczyk and her staff have "some excellent and very helpful" contacts at Blue Cross/Blue Shield: "The MSNJ group is an important and influential account. As such, we have a certain amount of leverage with the Blues." As participating physicians well know, Ms. Wasielczyk's staff has an uncanny way of getting claim problems resolved.

Currently, there are two health care programs sponsored by MSNJ. The Society also sponsors a dental insurance plan that can be purchased in conjunction with the health care programs or by itself. All sponsored programs are designed to provide a comprehensive plan of benefits with the flexibility physicians need to meet their own insurance needs.

As the program administrator, Donald F. Smith & Associates negotiates contractual provisions, annual rate renewals, and other plan conditions on behalf of the MSNJ group. Much time and effort is spent negotiating special program enhancements requested by physicians, including guaranteed lifelong coverage for surviving spouses, coverage for children through age 23, and other advantages. However, as William B. Stephenson, president of the firm, freely admits, "The efforts of the service staff get all the attention, praise, and even the thank-you notes."

Complete information on the MSNJ-sponsored health care and dental programs, including an enrollment application, is available by calling 609/895-1616 and speaking with Gina Vitale. □

PLACEMENT FILE

The following physicians have written to the executive offices of MSNJ seeking information on opportunities for practice in New Jersey. The information listed below has been supplied by the physicians. If you are interested in any further information concerning these physicians, we suggest you make inquiries directly to them.

ANESTHESIOLOGY

Michael Silverberg, MD, 2020 Walnut St., Apt. 29K, Philadelphia, PA 19103. Yale 1983. Board eligible. Group or hospital. Available July 1991.

CARDIOLOGY

George D. Birmingham, MD, 3531 Salerno Ct., Apt. 5, Middleton, WI 53562. Mount Sinai 1984. Board eligible. Board certified (IM). Group or partnership. Available July 1991.

INTERNAL MEDICINE

Won-Kook Chung, MD, 70 Hampshire Dr., Plainsboro, NJ 08536. Catholic Medical College (Korea). Board eligible. Group or solo. Available July 1991.

Thomas P. Hooker, DO, 2804 Sitios St., Tampa, FL 33629. Philadelphia College of Osteopathic Medicine 1984. Board certified; also, PUL. Solo or multispecialty group. Available July 1991.

Marc Kesselhaut, MD, 1 Rustic Ridge, C16, Little Falls, NJ 07424. St. George's University 1986. Board eligible. Solo or partnership in Mercer, Somerset, Burlington, Hunterdon, or Middlesex counties. Available.

PATHOLOGY

Charles F. Romberger, MD, 4501 Park Glen Rd., #241, St. Louis Park, MN 55416-4874. Temple 1986. Board eligible. Partnership or group. Available.

PEDIATRICS

Donna Churlin, MD, 55 Montgomery St., Bloomfield, NJ 07003. UMDNJ 1987. Board eligible. Partnership or group in central New Jersey (Essex, Union, or Morris counties). Available July 1991.

SURGERY

Nicholas J. Dudas, MD, 915 Princeton Ave., Philadelphia, PA 19111. UMDNJ 1986. Board eligible. Group or partnership. Available July 1991.

UROLOGY

Jeffrey L. Gevirtz, MD, 400 Narragansett Pkwy., Apt. SC7, Warwick, RI 02888. UMDNJ-Robert Wood Johnson Medical School 1986. Board eligible. Group or partnership. Available July 1991.

S. Misra, MD, 8161 Gatewood Dr., Clay, NY 13041. SCB-Orissa (India) 1977. Board eligible. Group or partnership. Available July 1991.

Medical Newsletter On

HOW TO PASS BOARD OF INTERNAL MEDICINE

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Medical Newsletter

5 Cullen Drive, West Orange, NJ 07052

June 10-14th, 1991

Update Your Medicine Seventeenth Annual CME Course with Hands-on Workshop. New York City sponsored by the Dept. of Medicine Cornell University Medical College and the Association of Practicing Physicians of the New York Hospital. Category I credit. Information: Lila A. Wallis, MD, Director and Debora A. Laan, Coordinator/445 East 69th Street, Olin 328, New York, NY 10021.
Telephone: 212-746-4752

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LOCATIONS AND DATES:

• FT. LAUD.	Feb. 16-17	• CHICAGO	July 13-14
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• NYC	April 20-21	• ATLANTA	Oct. 12-13
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"Physiology of Respiration During Sleep"
Robert A. Capone, M.D., FCCP
Medical Director, Sleep Disorder Center of Greater New Jersey

"Clinical Aspects of Sleep Apnea Syndromes"
David M. Rapoport, M.D., FCCP
Medical Director, Bellevue Sleep Laboratory, New York, NY

"Treatment of Obstructive Sleep Apnea with CPAP & BiPAP"
Mark H. Sanders, M.D., FCCP
Director, Pulmonary Sleep Evaluation Laboratory, Presbyterian-University Hospital, Pittsburgh, PA

"Surgical Treatment of Obstructive Sleep Apnea"
Department of Otolaryngology,
Morristown Memorial Hospital

"Sleep and Other Respiratory Disorders"
Mark J. Atkins, M.D., FCCP
Instructor, Clinical Medicine, Columbia University
Attending Physician, Morristown Memorial Hospital

SLEEP DISORDER CENTER OF GREATER NEW JERSEY

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A SYMPOSIUM ON ETHICS

HEALTH CARE: A RIGHT OR PRIVILEGE?

■ **BE IT RESOLVED:**
"Healthcare in the United States is a fundamental right and should not be rationed."

FOR:

Edmund D. Pellegrino, MD
Director of the Center for the Advanced Study of Ethics & John Carroll Professor of Medicine & Medical Humanities, Georgetown University, Washington, D.C.

AGAINST:

Daniel Callahan, Ph.D.
Director, The Hastings Center, Briarcliff Manor, New York

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Saturday, April 6, 1991
8:30 a.m.—Continental Breakfast
9:30 a.m.—Program
Alumni Hall, 11th & Locust Sts.
Thomas Jefferson University

■ **FOR FURTHER INFORMATION**
Contact the Office of Continuing Medical Education, Jefferson Medical College (215) 955-6992

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Department of Continuing Medical Education
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One Cooper Plaza, Camden, New Jersey 08103
(609) 342-3074

June 22, 1991

11th ANNUAL ADVANCES IN GASTROENTEROLOGY

Bally's Park Place Hotel and Casino
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(609)848-1000

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SEPTEMBER 15, 16, 17, 1991
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Faculty:

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- **A symposium designed for the general medical practitioner, orthopedist, neurologist, chiropractor, physical therapist and rehabilitation specialist. This program will expose the participant to the most recent, scientifically supported, conservative treatment approaches and review of current diagnostic procedures available.**

Information:
Maria De Francesco, CE Director
East Coast Continuing Education Center, Inc.
1585 Morris Ave., Union, NJ 07083
(908) 686-0836

CONTINUING EDUCATION

ANESTHESIOLOGY

May

21 **Meeting**
6-9 P.M.—Ramada Inn, Clark
(NJ State Society of Anesthesiologists)

CARDIOLOGY

April

3 **Thrombolytic Therapy**
10:30-11:30 A.M.—St. Mary's Hospital, Passaic
(AMNJ)

May

5 **International Association of Cardiac Biological Implants**
9 A.M.-5 P.M.—The Vista, Washington, DC
(UMDNJ)

DERMATOLOGY

April

9 **Retinoids**
7-9 P.M.—Schering Corporation, Kenilworth
(Dermatological Society of New Jersey)

17 **Case Presentations**
6 P.M.—Rutgers Community Health Plan, U.S. Route 1, New Brunswick
(UMDNJ, Division of Dermatology)

May

15 **Case Presentations**
6 P.M.—Rutgers Community Health Plan, U.S. Route 1, New Brunswick
(UMDNJ, Division of Dermatology)

23 **Common Dermatoses**
1:30-2:30 P.M.—Essex County Hospital Center, Cedar Grove
(AMNJ)

INFECTIOUS DISEASE

April

10 **Identification and Management of HIV Infection**
9-10 A.M.—Elizabeth General Medical Center, Elizabeth
(AMNJ and NJDOH)

10 **AIDS Training for Hospital Health Educators**
2:30-3:30 P.M.—Ancora Psychiatric Hospital, Hammonton
(AMNJ and NJDOH)

16 **AIDS: Prevention and Management**
9 A.M.-4 P.M.—Robert Wood Johnson Medical School, Piscataway
(UMDNJ)

May

3 **Diagnosis and Treatment of AIDS**
12 Noon-1 P.M.—South Jersey Hospital System, Bridgeton
(AMNJ and NJDOH)

8 **Diagnosis and Treatment of AIDS**
2-3 P.M.—Welkind Rehabilitation Hospital, Chester
(AMNJ and NJDOH)

10 **Identification and Management of HIV Infection**
12 Noon-1 P.M.—South Jersey Hospital System, Bridgeton
(AMNJ and NJDOH)

10 **Diagnosis and Treatment of AIDS**
10-11 A.M.—Marlboro Psychiatric Hospital, Marlboro
(AMNJ and NJDOH)

13 **Lyme Disease**
7-8 P.M.—Wallkill Valley General Hospital, Sussex
(AMNJ and NJDOH)

22 **Diagnosis and Treatment of AIDS**
10:30 A.M.-12 Noon—Christ Hospital, Jersey City
(AMNJ and NJDOH)

MEDICINE

April

2 **Internal Medicine Update**
9 5:30-7:30 P.M.—Cooper Hospital/
16 University Medical Center,
23 Camden
30 *(Cooper Hospital/University Medical Center)*

2-19 **Comprehensive Course in Occupational Medicine**
8:30 A.M.-4:30 P.M.—RWJ Medical School, Piscataway
(UMDNJ)

2 **Psychotherapy of Intimacy Fears**
8:30-10 A.M.—Elizabeth General Medical Center, Elizabeth
(Elizabeth General Medical Center)

2 **Chromium: Environmental Contamination as a Potential Occupational Hazard**
12:15-1:30 P.M.—John Fitch Plaza, Trenton
(AMNJ)

3 **Malpractice Insurance**
10:30-11:30 A.M.—Christ Hospital, Jersey City
(AMNJ)

3 **Internal Medicine**
10 **Review Course**
17 4-7 P.M.—University Hospital,
24 New Brunswick
(AMNJ and UMDNJ)

5 **Clinical Nutrition**
9 A.M.-4 P.M.—Robert Wood Johnson Medical School, New Brunswick
(UMDNJ)

5 **Diabetes in Pregnancy**
12 Noon-1 P.M.—South Jersey Hospital System, Bridgeton
(AMNJ)

10 **Prevention of Lower Extremity Amputations**
2-3 P.M.—Welkind Rehabilitation Center, Chester
(AMNJ)

10 **CDS Prescribing Practices: Legal/Illegal**
10:30-11:30 A.M.—St. Mary's Hospital, Passaic
(AMNJ)

10 **New Developments in Emergency Care in New Jersey**
10:30-11:30 A.M.—Christ Hospital, Jersey City
(Jersey City)

10 **Neurology of Aging**
8 A.M.-5 P.M.—Hyatt Regency, New Brunswick
(UMDNJ)

PHILADELPHIA HEART INSTITUTE

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Cardiology Update

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Wednesday, 3 April 1991

The Sudden Death Crisis in America

Moderator: Leonard N. Horowitz, M.D.

3:00-3:30	Sudden death in the athlete: Lessons to be learned	*Jan R. Weber, M.D.*
3:30-4:00	Sudden death in the patient with heart failure: Can it be prevented?	*Mariell Jessup, M.D.*
4:00-5:00	Case Presentations	*Bradford Lin, M.D.*
	Panel Discussion	*Robert I. Katz, M.D.*
	Terry Langer, M.D.	*Stephen J. Nierenberg, M.D.*
	J. David Ogilby, M.D.	*Gary J. Vigilante, M.D.*

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11-14 **39th Annual Meeting and Scientific Assembly: New Jersey Academy of Family Physicians**
Caesar's Atlantic Hotel and Casino, Atlantic City
(NJ Academy of Family Physicians)

12 **Arthritis**
1-2 P.M.—North Princeton Developmental Center, Princeton
(AMNJ)

12 **Diabetic Retinopathy**
8:30-9:30 A.M.—United Hospitals Medical Center, Newark
(AMNJ)

13 **Gastrointestinal Disorders**
9 A.M.-4 P.M.—Robert Wood Johnson Medical School, New Brunswick
(UMDNJ)

16 **Renal Failure and Brain Function**
6:30-9:30 P.M.—Overlook Hospital, Summit
(Nephrology Society of New Jersey)

17 **Calcium Absorption, Abnormalities of Calcium and Vitamin D Metabolism**
10:30-11:30 A.M.—St. Mary's Hospital, Passaic
(AMNJ)

17 **Autologous Blood Transfusion**
10:30 A.M.-12 Noon—Christ Hospital, Jersey City
(AMNJ)

17 **Diabetes and Cardiovascular Diseases**
1:30-2:30 P.M.—Central New Jersey Medical Group, New Brunswick
(AMNJ)

18 **Anemia in the Elderly**
1:30-2:30 P.M.—Essex County Hospital Center, Cedar Grove
(AMNJ)

22 **Prevention of Lower Extremity Amputations**
1-2 P.M.—New Lisbon Developmental Center
(AMNJ)

23 **Changing Nature of Health Care Economics**
8 A.M.—St. Joseph's Hospital and Medical Center, Paterson
(St. Joseph's Hospital and Medical Center)

24 **New Treatments in Cerebrovascular Disease**
1:30-2:30 P.M.—Runnells Specialized Hospital, Berkeley Heights
(AMNJ)

24 **Nutritional Support**
10:30-11:30 A.M.—Christ Hospital, Jersey City
(AMNJ)

24 **Fluid Electrolyte Imbalance**
2:30-3:30 P.M.—Trenton Psychiatric Hospital, Trenton
(AMNJ)

25 **Pain Therapy**
12 Noon-1 P.M.—Centrastate Medical Center, Freehold
(AMNJ)

26 **Mental Retardation Journal Club**
11:30 A.M.-12:30 P.M.—Hunterdon Developmental Center, Clinton
(AMNJ)

26-27 **Controversial Issues in Preventive Medicine**
All day—Trump Regency, Atlantic City
(Cooper Hospital/University Medical Center)

28 **MSNJ Annual Meeting**
Atlantic City
(MSNJ)

May

1 **Diabetes in Pregnancy**
10:30-11:30 A.M.—Christ Hospital, Jersey City
(AMNJ)

1 **Nephrotoxicity of Common Drugs**
10:30-11:30 A.M.—St. Mary's Hospital, Passaic
(AMNJ)

1-8-15-22 **Internal Medicine Review Course**
4-7 P.M.—University Hospital, New Brunswick
(AMNJ and UMDNJ)

2 **QA Criteria Developmental**
1:30-2:30 P.M.—Essex County Hospital Center, Cedar Grove
(AMNJ)

3 **Treatment of the Resistive Patient**
10-11 A.M.—Marlboro Psychiatric Hospital, Marlboro
(AMNJ)

5 **Cardiac Biological Implants**
9 A.M.-5 P.M.—The Vista, Washington, DC
(UMDNJ)

6 **Diabetic Retinopathy**
1-2 P.M.—New Lisbon Developmental Center, New Lisbon
(AMNJ)

7-14-21-28 **Internal Medicine Update**
5:30-7:30 P.M.—Cooper Hospital/University Medical Center, Camden
(Cooper Hospital/University Medical Center)

8 **Arthritis**
10:30-11:30 A.M.—St. Mary's Hospital, Passaic
(AMNJ)

8 **Annual Morris Saffron Lecture**
9 A.M.-2:30 P.M.—MSNJ Headquarters, Lawrenceville
(Medical History Society of NJ)

8 **Prevention of Lower Extremity Amputations**
9-10 A.M.—Elizabeth General Medical Center, Elizabeth
(AMNJ)

9 **Prehospital Coronary Care**
10-11 A.M.—Hunterdon Developmental Center, Clinton
(AMNJ)

10 **Osteoporosis**
1-2 P.M.—North Princeton Developmental Center, Princeton
(AMNJ)

15 **Organ Procurement**
10:30 A.M.-12 Noon—Christ Hospital, Jersey City
(AMNJ)

16 **Religion Issues in Counseling and Psychotherapy**
8:30-10 A.M.—Elizabeth General Medical Center, Elizabeth
(Elizabeth General Medical Center)

29 **Physician Office Laboratory Workshop**
All day—Princeton
(American Society of Clinical Pathologists)

OBSTETRICS/GYNECOLOGY

April

3 **Common Gynecological Problems**
1:30-2:30 P.M.—Central New Jersey Medical Group, New Brunswick
(AMNJ)

5 **Diabetes in Pregnancy**
12 Noon-1 P.M.—South Jersey Hospital System, Bridgeton
(AMNJ)

11-13 **Cutting Edge '91: Information Update**
Ocean Plaza Hilton Resort Spa, Long Branch
(Monmouth Medical Center)

17 **Abortion and Reproductive Wastage**
7:30-8:30 A.M.—Overlook Hospital, Summit
(AMNJ)

May

10 **Osteoporosis**
1-2 P.M.—North Princeton Developmental Center, Princeton
(AMNJ)

HU

Hahnemann University

Department of Medicine Grand Rounds 8:30 a.m.-9:30 a.m.

March 1991-May 1991

MARCH 1991

March 6, 1991
CLINICAL PATHOLOGICAL CONFERENCE CHIEF MEDICAL RESIDENTS PRESENTATIONS
Marc Grobman, DO
An Pham, MD
Karen Tom, MD
Department of Medicine
Hahnemann University

March 13, 1991
A VIEW OF CORONARY REVASCULARIZATION
Robert L. Frye, MD
Professor and Chairman
Department of Medicine
Division of Cardiology, Mayo Clinic
Rochester, Minnesota

March 20, 1991
ERYTHROPOIETIN: RESPONSIBLE FOR RBC PRODUCTION AND SURVIVAL
Allan B. Schwartz, MD
Professor of Medicine
Hahnemann University

March 27, 1991
NEW DERMATOLOGIC ANTIFUNGAL AGENTS FOR CUTANEOUS INFECTIONS
Edgar B. Smith, MD
Professor and Chairman
Department of Dermatology
University of Texas, Medical Branch
Galveston, Texas

CUTANEOUS STAPHYLOCOCCUS AUREUS INFECTIONS IN AIDS PATIENTS
James J. Leyden, MD
Professor of Dermatology
University of Pennsylvania
Philadelphia, Pennsylvania

APRIL 1991

April 3, 1991

GENE THERAPY
William N. Kelley, MD
Executive Vice President of the University of Pennsylvania
CEO, University of Pennsylvania Medical Center
Dean, University of Pennsylvania School of Medicine

April 10, 1991

NEW OPTIONS IN HEART FAILURE THERAPY
Marc A. Pfeffer, MD, PhD
Cardiovascular Division
Brigham and Women's Hospital
Boston, Massachusetts

April 17, 1991

RHEUMATOLOGIC ADVANCES
William J. Koopman, MD
H.L. Holley Professor of Medicine
Director, Division of Clinical Immunology and Rheumatology; Director, Multipurpose Arthritic Center
University of Alabama/Birmingham

April 24, 1991

ANTIHYPERTENSIVE THERAPY: BENEFITS BEYOND BLOOD PRESSURE CONTROL
Randall Zussman, MD
Assistant Professor of Medicine
Director, Division of Hypertension and Vascular Medicine
Massachusetts General Hospital
Boston, Massachusetts

MAY 1991

May 1, 1991
CHRONIC BRONCHITIS: A SYNDROME WE THOUGHT WE UNDERSTOOD
Stephen Rennard, MD
Larson Professor of Medicine
Section Chief, Pulmonary and Critical Care Medicine
University of Nebraska
Omaha, Nebraksa

May 8, 1991
THE LAW, THE HOSPITAL, THE PHYSICIAN: MEDICAL MALPRACTICE
Max Borten, MD, JD
Adjunct Professor of Law
Suffolk University Law School
Boston, Massachusetts

May 15, 1991
HEPATORENAL SYNDROME
Murray Epstein, MD
Professor of Medicine
University of Miami School of Medicine
Associate Director, Nephrology Section
Veterans Administration Medical Center
Miami, Florida

May 22, 1991
ADENOSINE: A NEW ANTIARRHYTHMIC DRUG
Bruce B. Lerman, MD
Director, Clinical Electrophysiology
Division of Cardiology
New York Hospital/Cornell Medical Center
New York, New York

May 29, 1991
CHOLELITHIASIS—NEWEST MEDICAL AND SURGICAL TREATMENTS
Teruo Matsumoto, MD, PhD
Professor of Surgery
Hahnemann University
Harris R. Clearfield, MD
Professor of Medicine
Director, Division of Gastroenterology
Hahnemann University

Hahnemann University Department of Medicine
Wednesday Medical Seminar Series
8:30 AM-3:30 PM

March 27, 1991
TRENDS IN TREATMENT OF CUTANEOUS INFECTIONS

April 10, 1991
NEW OPTIONS IN HEART FAILURE THERAPY

April 17, 1991
RHEUMATOLOGIC ADVANCES

May 15, 1991
KIDNEY DISEASE, FLUID & ELECTROLYTES

Seminar Directors:

William S. Frankl, MD
Professor of Medicine
and Chairman
Department of Medicine

Allan B. Schwartz, MD
Professor of Medicine
Director, Continuing Medical Education
for the Department of Medicine

Location:

Classroom C (Alumni Hall)
2nd Fl. New College Bldg.
Hahnemann University (15th Street Entrance)
15th and Vine Streets, Philadelphia, PA

s an organization accredited by the Accreditation Council for Continuing Medical Education (ACCME), Hahnemann University designates this continuing medical education activity as Category 1 of the Physician's Recognition Award of the American Medical Association. One credit hour may be claimed for each hour of participation by the individual physician.

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31 **Annual Meeting**
Trump Plaza Casino Hotel, Atlantic City
(NJ Obstetrical and Gynecological Society)

June

1 **Annual Meeting**
Trump Plaza Casino Hotel, Atlantic City
(NJ Obstetrical and Gynecological Society)

ONCOLOGY

April

12 **Tumor Board**
11 A.M.-12 Noon—Wallkill Valley Hospital, Sussex
(AMNJ)

18 **Dinner Meeting**
6:30-9:30 P.M.—The Hyatt, New Brunswick
(Head and Neck Section, AMNJ)

25 **Tumor Board Conference**
12 Noon-1 P.M.—Newcomb Medical Center, Vineland
(AMNJ)

May

15 **Reception**
6:30-9:30 P.M.—The Manor, West Orange
(Head and Neck Oncology Section, AMNJ, and Radiation Oncology Section, AMNJ)

ORTHOPEDICS

April

16-21 **Annual Spring Meeting**
Walt Disney World Swan Hotel, Orlando, Florida
(NJ Orthopedic Society)

PATHOLOGY

April

11 **Clinical Pathology Conference**
7:30 A.M.—St. Joseph's Hospital and Medical Center, Paterson
(St. Joseph's Hospital and Medical Center)

May

16-18 **Annual Meeting**
Hotel Hershey, Hershey, Pennsylvania
(NJ Society of Pathologists/ Pennsylvania Association of Clinical Pathologists)

PEDIATRICS

April

16 **Pediatric AIDS in the Soviet Union**
12:15-1:30 P.M.—John Fitch Plaza, Trenton
(AMNJ)

19 **Juvenile Onset Diabetes**
12 Noon-1 P.M.—South Jersey Hospital System, Bridgeton
(AMNJ)

25 **Update in Pediatrics**
6:30-10 P.M.—Marriott Hotel, Saddle Brook
(AMNJ)

26 **Current Concepts in Pediatric Hematology-Oncology**
9 A.M.-3 P.M.—Hyatt Regency, New Brunswick
(The Valerie Fund Children's Center and AMNJ)

May

8 **Child Abuse—Neglect**
10:30 A.M.-12 Noon—Christ Hospital, Jersey City
(AMNJ)

7 **Identifying and Treating the Child with Autism**
8:30-10 A.M.—Elizabeth General Medical Center, Elizabeth
(Elizabeth General Medical Center)

PSYCHIATRY

April

4 **Anticonvulsants in the Treatment of Mania**
12 Noon-1 P.M.—Carrier Foundation, Belle Mead
(Carrier Foundation)

11 **Serotonergic Dysregulation in Aggression—Clinical Implications**
12 Noon-1 P.M.—Carrier Foundation, Belle Mead
(Carrier Foundation)

18 **Research Update: Substance Abuse**
12 Noon-1 P.M.—Carrier Foundation, Belle Mead
(Carrier Foundation)

23 **The Violent Patient**
1:30-3:30 P.M.—Trenton Psychiatric Hospital, Trenton
(AMNJ)

May

1 **Treatment of the Resistive Patient**
10-11 A.M.—Marlboro Psychiatric Hospital, Marlboro
(AMNJ)

2 **Suicide over the Life Cycle**
12 Noon-1 P.M.—Carrier Foundation, Belle Mead
(Carrier Foundation)

9 **Secondary Mania**
12 Noon-1 P.M.—Carrier Foundation, Belle Mead
(Carrier Foundation)

14 **Family Therapy in an International Perspective**
8:30-10 A.M.—Elizabeth General Medical Center, Elizabeth
(Elizabeth General Medical Center)

16 **Mental Health Dollar: Where Does It Go?**
12 Noon-1 P.M.—Carrier Foundation, Belle Mead
(Carrier Foundation)

20 **Drive, Ego, Object, and Self**
8:30-10 A.M.—Elizabeth General Medical Center, Elizabeth
(Elizabeth General Medical Center)

30 **Psychotherapy of Mania**
12 Noon-1 P.M.—Carrier Foundation, Belle Mead
(Carrier Foundation)

RADIOLOGY

April

18 **Radiology Meeting**
Saint Barnabas Medical Center, Livingston
(Radiology Society of NJ/AMNJ)

May

16 **Radiology Meeting**
Saint Barnabas Medical Center, Livingston
(Radiology Society of NJ/AMNJ)

SURGERY AND ITS SPECIALTIES

May

2-5 **Fifth Annual Meeting**
Pittsburgh, Pennsylvania
(Eastern Vascular Society)

15 **Postoperative Toxic Shock Syndrome**
10:30-11:30 A.M.—St. Mary's Hospital, Passaic
(AMNJ)

UROLOGY

May

1 **William P. Burpeau Award Dinner and Memorial Lecture**
7 P.M.—The Manor, West Orange
(Urology Section, AMNJ)

MSNJ Annual Meeting
April 28–May 1, 1991

Board Review Course in Cardiovascular Disease

Presented by

PHILADELPHIA HEART INSTITUTE

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and

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September 30–October 4, 1991

Adam's Mark Hotel
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This program is designed to provide the physician with an intensive survey of our current understanding of the clinical manifestations, pathophysiology and treatment of cardiovascular disease. The course will also prepare the physician for the Board Examination in Cardiovascular Disease.

For registration information contact:
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Presbyterian Medical Center designates this Continuing Medical Education activity for 44 credit hours in Category I of the Physicians' Recognition Award of the American Medical Association and The Pennsylvania Medical Society membership requirement.

IN MEMORIAM

Benjamin B. Adelman. At the age of 88, Benjamin Barnett Adelman, MD, passed away on November 26, 1990. Dr. Adelman was born in Chester, Pennsylvania, on April 5, 1902, and lived in Maplewood and West Orange. He graduated with a medical degree from the University of Pennsylvania School of Medicine, Philadelphia, in 1925. Dr. Adelman received his New Jersey medical license in 1926 and served a residency at Jersey City Medical Center from 1926 to 1929 and interned at Germantown Hospital, Philadelphia. Dr. Adelman maintained a practice in Newark and was affiliated with Saint Michael's Medical Center, Newark Beth Israel Medical Center, and Presbyterian Hospital, all in Newark. During World War II, Dr. Adelman served in the United States Navy Medical Corps as a lieutenant commander, in charge of the ophthalmology department at Norfolk Naval Hospital, Virginia. Dr. Adelman was a diplomate of the American Board of Ophthalmology; a fellow of the American College of Surgeons and of the American Academy of Ophthalmology and Otolaryngology; a member of the American Medical Association, of our Essex County component, and of the New Jersey Ophthalmological Society; and a Golden Merit Award recipient from the Medical Society of New Jersey.

August P. Ciell. Born in Eddystone, Pennsylvania, on July 3, 1919, otolaryngologist August Paul Ciell, MD, passed away November 16, 1990, at the age of 71. After Dr. Ciell received his medical degree from Temple University School of Medicine, Philadelphia, in 1944, he served in the United States Navy for 10 years. Dr. Ciell received his New Jersey medical license in 1955. Dr. Ciell resided in Collingswood and maintained a private practice in Haddonfield. Dr. Ciell was an instructor at Jefferson Medical College of Philadelphia; a diplomate of the American Board of Otolaryngology; a fellow of the American College of Surgeons and of the American Academy of Ophthalmology and Otolaryngology; and a member of our Camden County component, of the American Medical Association, and of the Association of Military Surgeons of the United States. Dr. Ciell was associated with West Jersey Hospital system.

Samuel M. Diskan. A resident of Margate City and Atlantic City, Samuel Morris Diskan, MD, died on November 20, 1990. Dr. Diskan was born in Philadelphia, on March 18, 1910. After graduating in 1934 with a medical degree from Temple University School of Medicine, Pennsylvania, Dr. Diskan interned at Atlantic City Medical Center and received his New Jersey medical license in 1935. Dr. Diskan maintained a practice in Atlantic City for 40 years and was affiliated with Atlantic City Medical Center, serving as head of the eye screening program; with Shore Memorial Hospital, Somers Point; and with the former Atlantic County Hospital for Mental Diseases, Northfield. Dr. Diskan was editor of the *Atlantic County Medical Bulletin*; a fellow of the American Academy of Ophthalmology and Otolaryngology and of the American College of Surgeons; a diplomate of the American Board of Ophthalmology; past-president of the New Jersey Academy of Ophthalmology; member of the Committee on the Conservation of Vision, Hearing, and Speech of the Medical Society of New Jersey; and a member of our Atlantic County component and of the American Medical Association. Dr. Diskan was a World War II United States Army veteran.

Joseph E. Kalbacher. Retired since 1987, pediatrician Joseph Edward Kalbacher, MD, passed away on December 1, 1990. Born in 1922, Dr. Kalbacher graduated with a medical degree from Cornell University Medical College in 1946. From 1947 to 1949, Dr. Kalbacher served as a captain in the United States Army Medical Corps in Hot Springs, Arkansas. Dr. Kalbacher then was a resident at Cornell University, New York Hospital until 1950. Dr. Kalbacher also served a fellowship in pediatric cardiology at New York University. Dr. Kalbacher received his New Jersey medical license in 1951, maintained a practice in Westfield, and was affiliated with Overlook Hospital, Summit, serving as chairman of the pediatrics department for four years. Dr. Kalbacher was a member of our Union County component and of the American Medical Association, a fellow of the American Academy of Pediatrics, and a diplomate of the American Board of Pediatrics.

William A. Kemick. Pediatrician William Andrew Kemick, MD, of

Columbia, South Carolina, died on October 31, 1990. Dr. Kemick was born on September 19, 1931, in Newark and earned his medical degree from Cornell University Medical College, New York, in 1957. Dr. Kemick served a residency and an internship at Syracuse Upstate Medical Center. Dr. Kemick received his New York medical license in 1959, and his New Jersey license in 1961. Dr. Kemick practiced in Burlington and was associated with the former Burlington County Hospital, Mount Holly, and the former Zurbrugg Memorial Hospital, Riverside. Dr. Kemick also worked at the New Jersey State Department of Health, Trenton. Dr. Kemick was a captain in the United States Army in the early 1960s. Dr. Kemick was a member of our Burlington County component and of the American Medical Association; he was a diplomate of the American Board of Pediatrics and a fellow of the American Academy of Pediatrics.

John Mc Kernan. Born in 1925 in Pittsburgh, Pennsylvania, John Mc Kernan died November 27, 1990. Dr. Mc Kernan resided in Livingston for 32 years. In 1955, Dr. Mc Kernan graduated with a medical degree from the State University College of Medicine, New York; served an internship and residency at Saint Michael's Medical Center, Newark, and earned his New Jersey medical license in 1956. Dr. Mc Kernan maintained a pediatrics practice in Livingston and was affiliated with Saint Michael's Medical Center, Presbyterian Hospital, East Orange General Hospital, Orange Memorial Hospital, and St. Mary's Hospital, Orange. Dr. Mc Kernan was a member of our Essex County component and of the American Medical Association; a diplomate of the American Board of Pediatrics; and a fellow of the Academy of Pediatrics. Dr. Mc Kernan served in the Navy during World War II.

Morton R. Milsner. Retired since 1976, family practitioner Morton Robert Milsner, MD, died June 18, 1990, in St. Petersburg, Florida. Dr. Milsner was born in New York City on April 27, 1904. After earning his medical degree from New York University School of Medicine in 1928, Dr. Milsner interned at Central Islip State Hospital, New York, and Lebanon Hospital, Bronx. Dr. Milsner received his New York and New Jersey medical licenses in 1928 and 1976, respectively. Dr. Milsner was a clinical pediatrician at Mt. Sinai Hospital; a clinical physician at Lebanon Hospital; a resident physician at Workman's Circle Home and Infirmary for the Aged; and a member of the American Medical Association and of our Middlesex County component. Dr. Milsner also maintained a practice in North Brunswick. A World War II veteran, Dr. Milsner served as a captain in the U.S. Army.

Bertold Salzmann. Word has been received of the death of Bertold Salzmann, MD, on November 23, 1990. Dr. Salzmann was born in Austria on September 30, 1911, and attended the University of Vienna, Austria, receiving his medical degree in 1935 and his New Jersey medical license in 1946. Dr. Salzmann maintained a practice in Jersey City and Linden. Dr. Salzmann was chief of gynecology at Jersey City Medical Center; and attending at Jersey City Medical Center, Elizabeth General Medical Center, and the former Harrison S. Martland Medical Center. Dr. Salzmann was a member of our Hudson and Union County components and of the American Medical Association; a diplomate of the American Board of Obstetrics and Gynecology; a fellow of the American College of Surgeons, of the American College of Obstetricians and Gynecologists, and of the American Society of Adolescent Psychiatry; and a clinical associate professor with UMDNJ, Newark.

Charles G. Stetson. At the grand age of 80, Charles Greaves Stetson, MD, passed away on May 10, 1990. On January 21, 1910, Dr. Stetson was born in Oxford, New Hampshire. In 1936, Dr. Stetson graduated from Cornell University Medical College, New York, with a medical degree and earned his New Jersey medical license in 1952. A board certified radiologist and oncologist, Dr. Stetson practiced at Englewood Hospital. Dr. Stetson was a member of our Bergen County component, of the American Medical Association, of the American Radium Society, and of the Radiological Society of North America. A major in the United States Army during World War II, Dr. Stetson also was a fellow of the American College of Surgeons and of the American College of Radiology. Dr. Stetson had retired to Palm Beach, Florida.

Kurt Zeltmacher. A Trenton resident for over 50 years, Kurt Zeltmacher, MD, died in Palm Beach Gardens, Florida, on October 27, 1990, at the age of 78. Dr. Zeltmacher was born in Carlsbad, Czechoslovakia, on May 24, 1912. After attending the University of Prague and earning his medical degree in 1936, Dr. Zeltmacher received his New Jersey medical license in 1944. Dr. Zeltmacher specialized in internal medicine and hematology, practicing in Trenton for over 40 years. He was affiliated with Mercer Medical Center, Trenton, and with Graduate Hospital, Philadelphia. Dr. Zeltmacher also was a physician for the Veteran's Administration Office, Trenton. A member of the American Medical Association, of our Mercer County component, and of the American Heart Association, Dr. Zeltmacher served in the United States Army Medical Corps as a captain during World War II. Dr. Zeltmacher retired almost one year ago.

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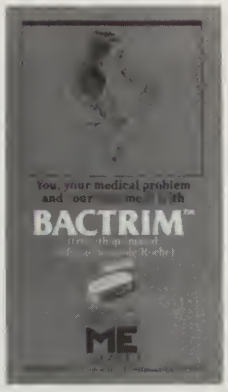


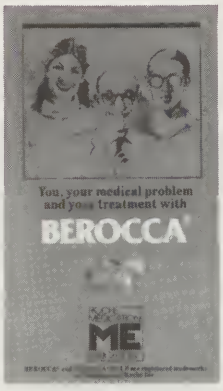
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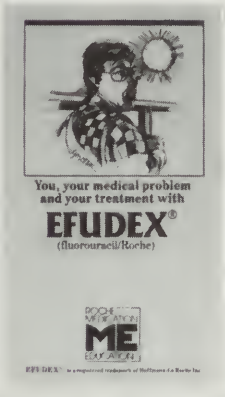
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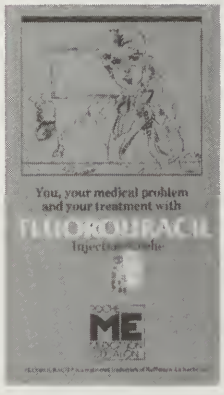
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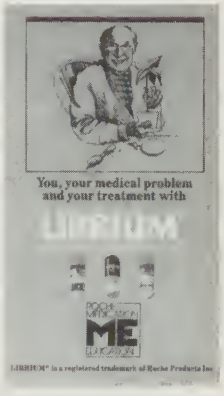
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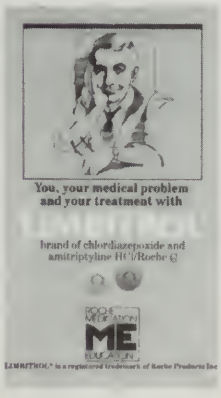
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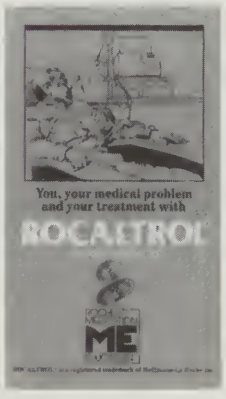


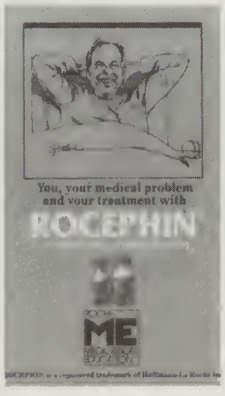














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Newswatch

HEALTH CARE REFORMS...

The Senate Committee of Institutions, Health and Welfare released S-3251 that generates omnibus reform measures. Sections being opposed by MSNJ include: a ban on physician ownership of referral centers; application of certificates of need to private practice; prohibition of physician dispensing; and promotion of generic prescriptions.

MANDATORY ASSIGNMENT UPDATE...

The New Jersey Assembly continues to consider A-4367 that would mandate government-approved rates for single seniors with an annual income of $34,125 and married couples at $41,875. All physicians are urged to contact their assemblymen to oppose this bill.

NEW PIP MEDICAL FEE SCHEDULE...

Effective February 16, 1991, there is a new PIP medical fee schedule. A postcard or note to MSNJ requesting a copy will be your most immediate source.

MEDICAL WASTE REGISTRATION...

The New Jersey State Department of Environmental Protection (DEP) has increased actions against physicians who are not complying with medical waste laws. MSNJ has arranged with the DEP to conduct a special registration effort to give physicians a reasonable opportunity to comply. **Please be on the lookout for the special mailing if your office is not already registered.**

SBME--BUSINESS PRACTICE RULES...

The State Board of Medical Examiners (SBME) has scheduled a hearing for May 29, 1991, on its controversial rules on medical business practices. MSNJ has offered comments in opposition and also will testify at the hearing.

MEDICARE--AT IT AGAIN...

The new federal budget proposal would limit Part B carriers to responding only to one out of every four inquiries received from patients or physicians. The AMA, MSNJ, and the New Jersey Congressional Caucus have lodged vigorous protests.

April 1991

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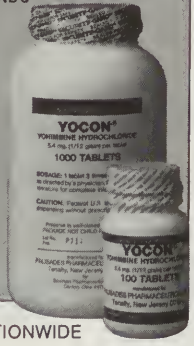
Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

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References:

1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188 McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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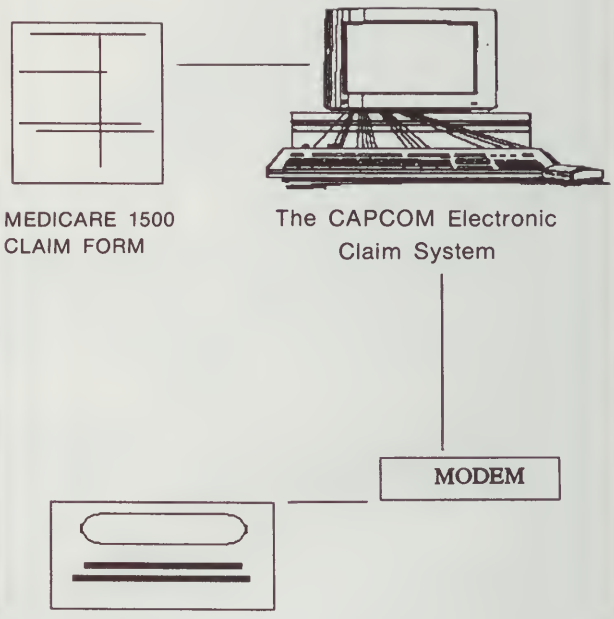
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MSNJ NEWSLETTER

PHYSICIAN SUPPLY

Continuing concern over the formulation of appropriate physician manpower policies has sparked interest over the last several years in physician supply and utilization trends. Within the AMA, Report T of the Board of Trustees (A-86) recommended that the AMA analyze physician manpower issues, including physician supply. Outside the AMA, ongoing interest in physician supply projections is studied by the Council on Graduate Medical Education (COGME), a congressionally mandated group residing in the Department of Health and Human Services. One of COGME's principal responsibilities is making recommendations for fine-tuning Medicare reimbursement of graduate medical education, based on their evaluation of the adequacy of future physician supply.

The Center's most recent projections indicate that physician supply will continue to increase over the next several years. Certain segments of the physician population will experience particularly rapid periods of growth, most notably, female physicians. The Center will continue to monitor physician supply trends and make projections on a periodic basis. Copies of the full report, entitled "Projections of Physician Supply: 1990 Update," are available for $3.00 by calling Anita King at 312/464-4352.

RECOGNITION AWARD

The AMA House of Delegates adopted a significant revision of the Physician's Recognition Award (PRA) at its 1990 Interim Meeting.

The definition of CME remains unchanged; the overall number of credit hours required for a three-year certificate continues to be 150, the definition and minimum number of AMA PRA category 1 credit hours remain unchanged, and a CME sponsor must still be accredited by ACCME or a state medical society to designate and award AMA PRA category 1 credit. Reciprocity agreements between the AMA PRA and many specialty society certificates continue in force, and the AMA PRA continues to meet the CME requirement for reregistration of license in many states.

The significant change in the PRA is in category 2. The revised PRA requires the same number of category 2 credit hours as category 1, i.e. 60 credit hours for a three-year certificate.

The requirement of category 2 credit hours should be a welcome change to accredited providers of CME. In the past, accredited providers tended to concentrate entirely on category 1 activities. If an activity was not designated category 1, it was viewed as somehow inferior. Hence, less structured, more flexible activities were overlooked. Innovation and rapid response to urgent educational needs and unanticipated opportunities was difficult (category 1 activities usually require months of planning).

Physician learners and CME professionals also welcome the new emphasis on category 2. Physicians are encouraged to be self-directed learners, selecting CME activities that are most effective for their individual needs regardless of the credit involved. Attention is directed to the value of discussion with colleagues, consultations, and the use of electronic databases in a physician's continuing education.

CME activities that can be reported for category 2 credit include:

1. Personal learning experiences: consultation with peers and medical experts, use of electronic databases in patient care, self-assessment activities, quality care review, and journal clubs.
2. Teaching in undergraduate, graduate, and continuing medical education as well as in other health professional education.
3. Medical writing and presentation of papers.
4. Organized CME activities not designated category 1 (conferences, seminars, or workshops).

Reading medical literature is essential to every physician's CME program, and it is expected that every applicant for the PRA spends time each week reviewing medical literature. Reading medical literature however, is not included in category 2 education because the PRA wants to recognize the reading of medical

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literature as a separate and very important source of CME for all physicians.

The revised requirements for the AMA PRA are: 150 hours of CME over a three-year period for a three-year PRA certificate (100 hours for a two-year certificate; 50 hours for a one-year certificate); 60 of these hours must be in category 1; 60 of these hours must be in category 2; and the remaining 30 hours may be in either category 1 or category 2.

DISABILITY BENEFITS

The Council on Medical Services heard a presentation by Mr. William Schwarz, assistant director of the state Disability Insurance Service, New Jersey State Department of Labor. This agency is responsible for administering temporary disability benefits (TDB) for over 3.2 million workers in New Jersey. The TDB program is funded by contributions from workers and employers and includes the basic state plan and a private plan option.

The Disability Insurance Service processed over 190,000 claims in 1990 and paid $260 million in benefits. Mr. Schwarz emphasized the important role the medical community plays in providing accurate and complete medical documentation to enable the agency to process and pay temporary benefits on a timely basis to individuals unable to work due to a nonoccupational illness or injury. If you have any questions relating to a specific claim or the temporary disability benefits program in general, contact Dr. Guillermo Gonzalez, the agency's supervising medical examiner at 609/984-3548.

In order to insure program integrity, the agency also utilizes the services of physicians located throughout the state to conduct independent medical examinations.

The Disability Insurance Service is interested in enhancing its communications and interaction with the medical community. Anyone interested in participating in the independent medical examination program or in having a speaker should contact: William J. Schwarz, Disability Insurance Service, New Jersey State Department of Labor, CN 387, Trenton, New Jersey 08625-0387.

PHYSICIAN SERVICES

The Omnibus Budget Reconciliation Act of 1989 (OBRA89) included a package of Medicare physician payment reforms. The motivation for reform was dissatisfaction with the persisting high rates of growth in Medicare physician expenditures. Among the reforms was a program of Medicare Volume Performance Standards (MVPS).

The purpose of MVPS is to provide a basis for considering expenditure growth in setting the conversion factor each year under the payment schedule; if actual expenditure growth were to exceed the MVPS, payment updates could be reduced. Hence, determination of the MVPS has the potential to play a crucial role in setting payment amounts. Although Congress retains the discretion to set the MVPS each year, OBRA89 includes a provision for Congress to receive recommendations from the Department of Health and Human Services (HHS) and the Physician Payment Review Commission (PPRC). HHS and PPRC have employed actuarial schemes, yielding MVPS recommendations of 9.9 percent and 11.2 percent, respectively, for fiscal year 1991. Neither approach is based on any sort of theoretical underpinning. As such, neither approach considers the role of basic economic forces such as beneficiary demand. Additionally, both recommendations for fiscal year 1991 include arbitrary cuts in the allowance for service volume growth.

The Reynolds and McMenamin study demonstrates the importance of beneficiary demand in Medicare physician expenditure growth. The HHS and PPRC methodologies differ in two important respects from the Reynolds and McMenamin methodology:

1. The HHS and PPRC approaches are true actuarial methods. As such, neither approach examines the role of important economic factors such as beneficiary demand in expenditure growth. Failure to include the influence of beneficiary demand may result in projections that systematically will understate the actual growth.
2. The HHS and PPRC recommendations include arbitrary cuts in the allowance for service volume growth.

In evaluating the extent to which growth in excess of the MVPS will be reflected in the conversion factor, it will be extremely difficult to determine the extent to which desired reductions in volume failed to materialize; the difference may simply reflect projection errors, or it may reflect an inability to hold service volume growth below an arbitrary and unreasonably low level. In such instances, physicians may be unfairly penalized.

PHYSICIANS LIAISON GROUP

The mechanism for reporting physicians to the Office of the Inspector General was discussed at length at the February 13, 1991, meeting of the Medicare Physicians Liaison Group. Of particular concern, was the sense of threat on receipt of a computerized letter advising a physician of exceeding MAAC. We were assured that no one has been fined and that these letters are educational. The only physicians to be referred to the in-

spector general clearly and persistently have abused the system. Further discussion revolved around anti-hassle legislation passed by Congress. We also were informed that screening parameters have been released to the newly formed medical advisory committee to HCFA.

The problem of verbiage contained in carrier letters to physicians was debated. A motion was passed to form a subcommittee to review letters prior to general distribution. Where there is no confict with HCFA rulings, the committee will suggest editorial comment and explanation. It is hoped that this will ameliorate the sometimes threatening nature of this correspondence.

The significance of Medicare reports to providers was stressed. The reports contain details of current Medicare policy and the carrier is bound by the information contained therein. It behooves providers to be absolutely familiar with the contents of these reports, and so avoid billing and other problems.

Two lists were issued containing codes for over 300 procedures where HCFA deemed an assistant at surgery to be unnecessary. These lists were found to be flawed, containing such obvious anomalies as pancreatectomy, reimplantation of an arm, and a number of cardiac operations. Mr. Hartmann acknowledged HCFA's error and said the issue was being studied; the list would be revised. Unfortunately, HCFA will not retract the current lists while the matter is being investigated, although this would seem reasonable. A motion was unanimously passed to request that HCFA withdraw these lists pending further analysis.

The concept of the independent procedure (IP) was discussed at length. Clearly, with unbundling of services abuses occur, and IPs were introduced to address this. However, it was pointed out that there are numerous examples where more than one IP must be performed concurrently in the interests of good patient care. Dr. Ricci accepted this philosophy and will develop an improved mechanism for reporting and payment of legitimate, concurrent IP services.

The problem of incomplete schedules of limiting fees was noted. It was stated that knowledge of these fees was essential in order to comply with the OBRA requirement of preoperative disclosure where the bill would exceed $500. Furthermore, it would be unreasonable to have to wait weeks for this information before being able to bill a patient. Mr. Bryant assured us that his staff has been instructed to release this information, by telephone, on the request of a physician or a member of the doctor's staff. The information for up to five codes will be released for each telephone call. Additionally, a complete listing of all prevailing participating and nonparticipating schedule of fees will be sent to the medical staff of a hospital on request.

The 60 percent limitation on payment for nonoffice outpatient surgery was discussed. The development of the list was determined by computer search and consultation with Blue Shield experts. However, the list is not cast in stone. As an example, extracorporeal lithotripsy was mentioned. A physician who feels that a procedure on this list is inappropriate should contact the Medical Society of New Jersey to petition for its removal.

Global fees for operative and interventional procedures were discussed, as these are targeted in the planned budget for fiscal year 1992. A new subcommittee was formed to draft a letter to the authorities outlining objections to the concept in the strongest possible terms.

In light of the enormous managerial and delivery problems that are inherent in the Medicare system, it was unanimously agreed to invite congressional delegates to send observers to meetings of the liaison committee. It is felt that exposing them to our deliberations would improve their understanding of the difficulties physicians face.

On a more upbeat note, I am happy to report that Blue Shield will appoint nonparticipating physicians to their panel of consultants. We also were informed that HCFA has released $75 million to aid in claim processing. This will negate the threat of delays in payment for services rendered to Medicare recipients. Finally, the Committee voted unanimously to petition the administration to remove from office Mr. Kusserow, the inspector general. □ Ian D. Samson MD, vice-chairman, Medical Liaison Committee to Pennsylvania Blue Shield

TOP HONORS

Richard L. Levine, MD, a member of our Mercer County component, is the recipient of the 1991 Small Business Person of the Year Award. Dr. Levine will represent New Jersey at White House ceremonies on May 6-7, 1991. An emergency medicine physician, Dr. Levine is affiliated with Hamilton Hospital and is president, Professional Medical Services of Lawrenceville. Dr. Levine earned his medical degree from the State University of New York, Downstate Medical School, Brooklyn, New York, in 1975.

HEALTH PRACTICES

The New Jersey State Department of Health has launched a year-long telephone survey to assess the personal health practices of New Jersey residents. Any resident with a telephone number, whether listed or unlisted, may receive a 20-minute interview call, involving a variety of health issues. The interviews will be conducted on weekday afternoons and evenings, and on the weekends during the late morning through the evening.

FINI

"Love is blind—marriage is the eye opener." □

Regulated Medical Waste Transporters

The following list was supplied by the New Jersey State Department of Environmental Protection (NJDEP); the list includes only transporters registered with NJDEP who have notified the Environmental Protection Agency (EPA) and have received an EPA identification number, and are Board of Public Utilities certified medical waste transporters.

Transporter	Address	City	State	Zip	Telephone #
BAR-ELA, Inc., t/a Monarch Disposal	P.O. Box 652	Piscataway	NJ	08854	201/968-4046
Bridgeview Inc.	RR 1, Box 364	Morgantown	PA	19543	215/286-6996
Browning Ferris Industries, S. Jersey	Box 74-A Cranbury Station Rd #4	Cranbury	NJ	08512	215/641-1700
Chambers Waste Systems of NJ Inc.	9 Sylvan Way	Parsippany	NJ	07054	201/326-9883
Cifaloglio Inc.	121 Harding Highway	Landisville	NJ	08326	609/697-3159
Coast Medical Supply Inc.	3 Shelia Drive, Suite 4	Tinton Falls	NJ	07724	201/842-5655
Consolidated Waste Services	1301 Route 37 West	Toms River	NJ	08755	201/341-3333
Controlled Medical Disposal Inc.	39 Massar Street	Clark	NJ	07066	201/574-3838
Daniello Carting Company	12 Lark Avenue	White Plains	NY	10607	914/592-5006
Domenick Pucillo Disposal Inc.	1420 Chestnut St.	Hillside	NJ	07203	201/687-7770
East Coast Medical Waste Inc.	1307 South Pennsylvania Ave.	Morrisville	PA	19067	609/392-3229
East Orange General Hospital	300 Central Avenue	East Orange	NJ	07019	201/266-4493
Environmental Control Co. Inc.	1830 Gilford Avenue	New Hyde Park	NY	11040	516/248-7345
Interboro Disposal	1024 Jefferson St.	Hoboken	NJ	07030	201/963-4111
Interstate Waste Removal	208 Patterson Ave.	Trenton	NJ	08610	609/587-1500
K.S. Processing Co.	201 E. 10th Street	Marcus Hook	PA	19061	215/494-4606
Medi-Waste Systems, Ltd.	95 Eads St.	West Babylon	NY	11704	516/249-3131
Medical & Hazardous Waste Mgt. Corp.	4001 Boston Rd.	Bronx	NY	10466	212/325-8100
Medical Waste Systems, D/B/A Bio Systems	380 Constance Drive	Wesminster	PA	18974	215/672-8888
MIT Waste Division Inc.	P.O. Box 393—Rt. 73 & Beech Ave.	Berlin	NJ	08009	609/753-0118
Montrose Manning Inc.	8504 West Chester Pike	Upper Darby	PA	19082	215/789-2988
Nappi Trucking Corp.	P.O. Box 510	Matawan	NJ	07747	201/566-3000
National Waste Disposal	432 Stokes Ave.	Trenton	NJ	08638	609/883-1420
Orchard Hill Memorial Park Inc.	75 Stirling Rd.	Warren	NJ	07060	201/754-9286
Regional Carting Company	P.O. Box 70	Morganville	NJ	07751	201/988-8040
Rollins Env. Services	P.O. Box 337	Bridgeport	NJ	08014	609/467-3100
S-J Transportation Co.	U.S. Route 40, P.O. Box 91	Woodstown	NJ	08098	609/769-2741
Schering Corp.	1011 Morris Avenue	Union	NJ	07083	201/298-4460
Shore Memorial Hospital	New York Avenue	Somers Point	NJ	08244	609/653-3594
Solid Waste Technologies	50 Mt. Bethel Road	Warren	NJ	07060	201/561-3111
T.J. Egan & Company	5 Lawrence St.	Bloomfield	NJ	07003	201/680-4840
Tetro & Sons Trucking Inc.	P.O. Box 44	Union Beach	NJ	07735	201/264-4477
The NDL Organization Inc.	1000 Lower South St. Box 791	Peekskill	NY	10566	914/737-7200
White Brothers Trucking	864 Julia Street	Elizabeth	NJ	07201	201/289-3222

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PROFESSIONAL LIABILITY

DONATED BLOOD

A federal tort claims act action by a servicewoman who was erroneously advised that she tested positive for AIDS was not barred by the Feres doctrine, a federal trial court in the District of Columbia ruled.

The complainant was on active duty as a member of the United States Army. On September 9, 1986, she voluntarily donated blood at a public blood drive sponsored by the hospital where she was stationed. About a month later she was advised that her blood had tested positive for AIDS. At the same time a second blood sample was taken to perform followup confirmatory tests. Hospital personnel continued to advise her that she had AIDS until February 3, 1987, when she was told by a physician that there had been a mistake, that she did not have AIDS, and that there had been an error in the paperwork.

In the meantime, the patient had been diagnosed as pregnant and had an abortion on December 4, 1986. She submitted a claim for $750,000, that was rejected. She then filed suit. The court said that the Feres doctrine that barred actions by service personnel that arose out of or in the course of activity incident to service did not bar her claim. Her donation of blood was not incident to service, the court said.

The court denied the government's motion to dismiss the case. (Reprinted with permission, *The Citation* 62:41, 1990.)

MAMMOGRAM QUALITY

Improvements in mammograms over the last five years reinforce mammography's value in detecting early breast cancer.

Images are clearer than ever, according to FDA surveys. From 1985 to 1988, average image-quality score increased from 7.8 to 9.9, with 8 considered acceptable. Scoring was based on the number of tiny objects embedded in special plastic devices called phantoms that showed up on film when x-rayed. The percentage of mammography equipment providing substandard images declined from 36 percent in 1985 to 13 percent in 1988.

Dr. Fred Rueter of the FDA Center for Devices and Radiological Health attributed the enhanced image quality to equipment improvements and screen and film developments. Where as slightly more radiation was used to achieve the improved images, radiation levels were about two-thirds less than those used in 1979 and remained within FDA safety guidelines.

Even a substandard image may detect cancer earlier than breast self-examination alone, said FDA researchers. Assistant Secretary for Health James Mason said he hopes the surveys will encourage women to make greater use of mammography. (Reprinted with permission, *Medical World News* 32:31, 1991.)

OB POLICY LIMIT

An obstetrician was released from liability for the wrongful death of a patient whose uterus ruptured during labor, when he deposited the maximum liability amount of $100,000 under the Medical Malpractice Act, the Louisiana Supreme Court ruled.

The patient was in labor for the birth of her fifth child on February 9, 1979. About ten and one-half hours after her admission, her uterus ruptured, and she died as a result of a massive amniotic fluid embolism. The child survived but suffered anoxic brain damage prior to his delivery by emergency cesarean section. The husband filed a wrongful death action and a personal injury action on behalf of his infant son against the obstetrician and the hospital.

The medical review panel found that the obstetrician failed to comply with the appropriate standard of care as charged in the complaint. The physician and his insurance company deposited the $100,000 limit of his policy for each of the two claims. The Patient's Compensation Fund then settled each claim for $400,000 plus $200,000 in accrued interest plus the $100,000 deposited by the physician's insurance company.

The husband then filed an amended personal injury action and contended that the $500,000 limitation in the statute was unconstitutional. A trial court dismissed the action, and an appellate court affirmed.

Affirming the decision, the Louisiana Supreme Court said that the husband had accepted the settlement and could not challenge the constitutionality of the recovery limitation. When the physician's insurance company deposited the $100,000 policy limit, the physician admitted his liability. The $100,000 policy limit was the maximum amount the obstetrician could be held liable, the court said. (Reprinted with permission, *The Citation* 62:42,1990.)

PROFESSIONAL LIABILITY

James E. George, MD, JD, is the director of the Department of Professional Liability Control, and A. Ronald Rouse is director of special projects, Medical Society of New Jersey. If you have questions or concerns, please call MSNJ headquarters at 609/896-1766. □



EDITOR'S DESK:

IN THE SPRING

In the spring, a young man's fancy lightly turns to . . . and it is a time for snows to have receded and yielded to warmer weather, for the dark, drab colors of winter to be replaced by the brighter ones of spring. In a poor attempt to rival nature, the fashion industry brings forth its new lines, covering the human form in new garb, as the spring season covers the earth with the brilliance of new life and growth. Thus, it is appropriate for *NEW JERSEY MEDICINE* to display its new raiment at this time.

With stimulation from the executive editor and staff and the approval of the Committee on Publication, we developed a clean and distinct design that will continue for years. Although we have received a number of journalistic awards in recent years, we felt some changes and improvements still were warranted to further enhance our journal.

Since its initial publication on a monthly basis in 1904, *The Journal of the Medical Society of New Jersey,* renamed *NEW JERSEY MEDICINE* in 1985, has existed to aid the physicians of New Jersey in practical and scientific matters according to current standards. The more than 11,000 physician readers deserve continual review of this periodical to ensure maintenance of these standards.

Some of the changes are subtle, but should be apparent to the observant viewer. Our logo, unique to us, is new. The layout of pages has been redesigned, graphs and tables have been altered, and the use of columns has been revised. Type sizes also have been changed, the bolder ones being softened and the smaller ones being enlarged, a boon to those not willing to concede a measure of presbyopia. Other refinements also are planned, the better for you to see us.

Journal redesigns are not done lightly. They represent months of anguish and doubt on the part of the editorial staff and the review committee. They never receive unanimous approval. The artistic and individualistic bent in each of us is to be expected; we all feel we could improve the product offered with a small addition here, a small deletion there, and a small alteration somewhere else. Nevertheless, here is our baby. We hope you welcome the new edition to the family with open arms. Let us know how you feel.

No Winter lasts forever, no Spring skips its turn. April is a promise that May is bound to keep, and we know it. Hal Borland, *"A Promise-April 29."* Sundial of the Seasons, 1964.

As we noted last year, the time has come for Agra on the Atlantic. The 225th Annual Meeting of the Medical Society of New Jersey will be held at the Trump Taj Mahal Casino/Resort in Atlantic City, beginning on April 27, 1991. Please join us. □

Howard D. Slobodien, MD

One Of A Kind

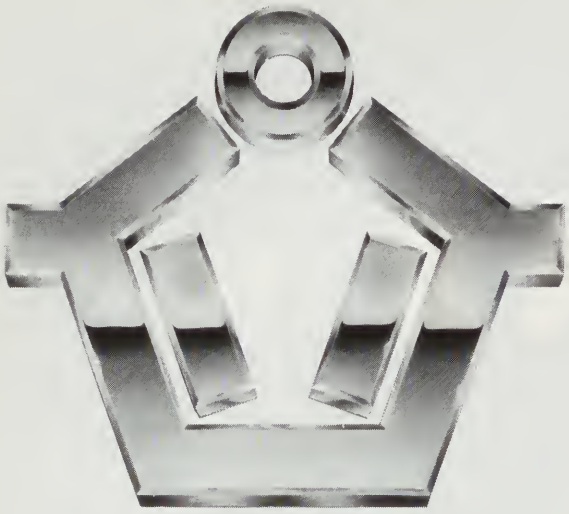


Zantac®

ranitidine HCl/Glaxo 150 mg and 300 mg tablets

Please see Brief Summary of Prescribing Information on adjacent page.

Glaxo/ ROCHE



One Of A Kind

Zantac®

ranitidine HCl/Glaxo 150 mg and 300 mg tablets

Zantac® 150 Tablets **BRIEF SUMMARY**
(ranitidine hydrochloride)

Zantac® 300 Tablets
(ranitidine hydrochloride)

Zantac® Syrup
(ranitidine hydrochloride)

The following is a brief summary only. Before prescribing, see complete prescribing information in Zantac® product labeling.

INDICATIONS AND USAGE: Zantac® is indicated in:
1. Short-term treatment of **active duodenal ulcer.** Most patients heal within four weeks.
2. **Maintenance therapy** for duodenal ulcer patients at reduced dosage after healing of acute ulcers.
3. The treatment of **pathological hypersecretory conditions** (eg, Zollinger-Ellison syndrome and systemic mastocytosis).
4. Short-term treatment of **active, benign gastric ulcer.** Most patients heal within six weeks and the usefulness of further treatment has not been demonstrated.
5. Treatment of **gastroesophageal reflux disease (GERD).** Symptomatic relief commonly occurs within one or two weeks after starting therapy. Therapy for longer than six weeks has not been studied.

In active duodenal ulcer; active, benign gastric ulcer; hypersecretory states; and GERD, concomitant antacids should be given as needed for relief of pain.

CONTRAINDICATIONS: Zantac® is contraindicated for patients known to have hypersensitivity to the drug.

PRECAUTIONS:

General: 1. Symptomatic response to Zantac® therapy does not preclude the presence of gastric malignancy.
2. Since Zantac is excreted primarily by the kidney, dosage should be adjusted in patients with impaired renal function (see DOSAGE AND ADMINISTRATION). Caution should be observed in patients with hepatic dysfunction since Zantac is metabolized in the liver.

Laboratory Tests: False-positive tests for urine protein with Multistix® may occur during Zantac therapy, and therefore testing with sulfosalicylic acid is recommended.

Drug Interactions: Although Zantac has been reported to bind weakly to cytochrome P-450 *in vitro,* recommended doses of the drug do not inhibit the action of the cytochrome P-450-linked oxygenase enzymes in the liver. However, there have been isolated reports of drug interactions that suggest that Zantac may affect the bioavailability of certain drugs by some mechanism as yet unidentified (eg, a pH-dependent effect on absorption or a change in volume of distribution).

Carcinogenesis, Mutagenesis, Impairment of Fertility: There was no indication of tumorigenic or carcinogenic effects in lifespan studies in mice and rats at doses up to 2,000 mg/kg/d.

Ranitidine was not mutagenic in standard bacterial tests (*Salmonella, Escherichia coli*) for mutagenicity at concentrations up to the maximum recommended for these assays.

In a dominant lethal assay, a single oral dose of 1,000 mg/kg to male rats was without effect on the outcome of two matings per week for the next nine weeks.

Pregnancy: ***Teratogenic Effects: Pregnancy Category B***: Reproduction studies have been performed in rats and rabbits at doses up to 160 times the human dose and have revealed no evidence of impaired fertility or harm to the fetus due to Zantac. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

Nursing Mothers: Zantac is secreted in human milk. Caution should be exercised when Zantac is administered to a nursing mother.

Pediatric Use: Safety and effectiveness in children have not been established.

Use in Elderly Patients: Ulcer healing rates in elderly patients (65 to 82 years of age) were no different from those in younger age groups. The incidence rates for adverse events and laboratory abnormalities were also not different from those seen in other age groups.

ADVERSE REACTIONS: The following have been reported as events in clinical trials or in the routine management of patients treated with Zantac®. The relationship to Zantac therapy has been unclear in many cases. Headache, sometimes severe, seems to be related to Zantac administration.

Central Nervous System: Rarely, malaise, dizziness, somnolence, insomnia, and vertigo. Rare cases of reversible mental confusion, agitation, depression, and hallucinations have been reported, predominantly in severely ill elderly patients. Rare cases of reversible blurred vision suggestive of a change in accommodation have been reported.

Cardiovascular: As with other H_2-blockers, rare reports of arrhythmias such as tachycardia, bradycardia, atrioventricular block, and premature ventricular beats.

Gastrointestinal: Constipation, diarrhea, nausea/vomiting, abdominal discomfort/pain, and rare reports of pancreatitis.

Hepatic: In normal volunteers, SGPT values were increased to at least twice the pretreatment levels in 6 of 12 subjects receiving 100 mg qid intravenously for seven days, and in 4 of 24 subjects receiving 50 mg qid intravenously for five days. There have been occasional reports of hepatitis, hepatocellular or hepatocanalicular or mixed, with or without jaundice. In such circumstances, ranitidine should be immediately discontinued. These events are usually

Zantac® 150 and 300 (ranitidine hydrochloride) Tablets
Zantac® (ranitidine hydrochloride) Syrup

reversible, but in exceedingly rare circumstances death has occurred.

Musculoskeletal: Rare reports of arthralgias.

Hematologic: Blood count changes (leukopenia, granulocytopenia, thrombocytopenia) have occurred in a few patients. These were usually reversible. Rare cases of agranulocytosis, pancytopenia, sometimes with marrow hypoplasia, and aplastic anemia have been reported.

Endocrine: Controlled studies in animals and man have shown no stimulation of any pituitary hormone by Zantac and no antiandrogenic activity, and cimetidine-induced gynecomastia and impotence in hypersecretory patients have resolved when Zantac has been substituted. However, occasional cases of gynecomastia, impotence, and loss of libido have been reported in male patients receiving Zantac, but the incidence did not differ from that in the general population.

Integumentary: Rash, including rare cases suggestive of mild erythema multiforme, and, rarely, alopecia.

Other: Rare cases of hypersensitivity reactions (eg, bronchospasm, fever, rash, eosinophilia), anaphylaxis, angioneurotic edema, and small increases in serum creatinine.

OVERDOSAGE: Information concerning possible overdosage and its treatment appears in the full prescribing information.

DOSAGE AND ADMINISTRATION: (See complete prescribing information in Zantac® product labeling).

Active Duodenal Ulcer: The current recommended adult oral dosage is 150 mg or 10 ml (2 teaspoonfuls equivalent to 150 mg of ranitidine) twice daily. An alternate dosage of 300 mg or 20 ml (4 teaspoonfuls equivalent to 300 mg of ranitidine) once daily at bedtime can be used for patients in whom dosing convenience is important. The advantages of one treatment regimen compared to the other in a particular patient population have yet to be demonstrated.

Maintenance Therapy: The current recommended adult oral dosage is 150 mg or 10 ml (2 teaspoonfuls equivalent to 150 mg of ranitidine) at bedtime.

Pathological Hypersecretory Conditions (such as Zollinger-Ellison syndrome): The current recommended adult oral dosage is 150 mg or 10 ml (2 teaspoonfuls equivalent to 150 mg of ranitidine) twice a day. In some patients it may be necessary to administer Zantac® 150-mg doses more frequently. Doses should be adjusted to individual patient needs, and should continue as long as clinically indicated. Doses up to 6 g/d have been employed in patients with severe disease.

Benign Gastric Ulcer: The current recommended adult oral dosage is 150 mg or 10 ml (2 teaspoonfuls equivalent to 150 mg of ranitidine) twice a day.

GERD: The current recommended adult oral dosage is 150 mg or 10 ml (2 teaspoonfuls equivalent to 150 mg of ranitidine) twice a day.

Dosage Adjustment for Patients with Impaired Renal Function: On the basis of experience with a group of subjects with severely impaired renal function treated with Zantac, the recommended dosage in patients with a creatinine clearance less than 50 ml/min is 150 mg or 10 ml (2 teaspoonfuls equivalent to 150 mg of ranitidine) every 24 hours. Should the patient's condition require, the frequency of dosing may be increased to every 12 hours or even further with caution. Hemodialysis reduces the level of circulating ranitidine. Ideally, the dosage schedule should be adjusted so that the timing of a scheduled dose coincides with the end of hemodialysis.

HOW SUPPLIED: Zantac® 300 Tablets (ranitidine hydrochloride equivalent to 300 mg of ranitidine) are yellow, capsule-shaped tablets embossed with "ZANTAC 300" on one side and "Glaxo" on the other. They are available in bottles of 30 (NDC 0173-0393-40) tablets and unit dose packs of 100 (NDC 0173-0393-47) tablets.

Zantac® 150 Tablets (ranitidine hydrochloride equivalent to 150 mg of ranitidine) are white tablets embossed with "ZANTAC 150" on one side and "Glaxo" on the other. They are available in bottles of 60 (NDC 0173-0344-42) and 100 (NDC 0173-0344-09) tablets and unit dose packs of 100 (NDC 0173-0344-47) tablets.

Store between 15° and 30° C (59° and 86° F) in a dry place. Protect from light. Replace cap securely after each opening.

Zantac® Syrup, a clear, peppermint-flavored liquid, contains 16.8 mg of ranitidine hydrochloride equivalent to 15 mg of ranitidine per 1 ml in bottles of 16 fluid ounces (one pint) (NDC 0173-0383-54).

Store between 4° and 25° C (39° and 77° F). Dispense in tight, light-resistant containers as defined in the USP/NF.

July 1990

Glaxo Pharmaceuticals
DIVISION OF GLAXO INC.
Research Triangle Park, NC 27709

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ZAN858R2 Printed in USA October 1990

GUEST EDITORIAL: HEPATIC HEMANGIOMAS

Louis S. Zeiger, MD

Our guest writer comments on the use of computed tomography (CT) and magnetic resonance imaging (MRI) characteristics of giant hepatic hemangiomas, as discussed by Drs. Jacoby and DiMarcangelo beginning on page 281.

Hepatic cavernous hemangiomas are common benign lesions of the liver that occur in an autopsy series at about an average of 3 to 4 percent of all autopsies.[1]

Therefore, these lesions commonly are seen as incidental findings on computed tomography (CT) examinations in the abdomen performed for other diagnostic reasons. The diagnosis of hemangioma usually is implied on CT if indeed a precontrast CT and postcontrast CT were obtained. This is not performed, however, in all cases. The characteristic pattern described on CT is of peripheral contrast enhancement and this occurs in about 80 percent of these lesions. However, it must be pointed out that this pattern also is seen frequently in metastatic disease. So, therefore, using CT alone, one cannot distinguish between a metastatic lesion and a benign hemangioma. Drs. James Jacoby and Mark DiMarcangelo discuss this issue in their paper, "CT and MRI of Hepatic Hemangiomas," on page 281.



(Photo: Jacoby; DiMarcangelo)

Axial CT section through the liver; precontrast, mass in diminished attenuation (arrows).

Two additional imaging approaches can be used to more specifically diagnose this lesion. One is the utilization of ^{99m}TC-red blood cell or blood pool imaging to detect and specifically diagnose hemangiomas of the liver.[2] These lesions are shown to concentrate tracer as a function of time, that is ^{99m}TC-red blood cell concentration will increase within the first two hours postinjection. The overall accuracy of this procedure as in the above reference is 90 percent.

More recently, MRI using spin echo T2 weighted imaging clearly has shown an overall accuracy of 90 percent and it clearly is very useful in making a more specific diagnosis of hemangioma versus metastatic disease.

It is, therefore, apparent that the use of noninvasive technology, in this case MRI and ^{99m}TC-red blood cell imaging, can be utilized to make a specific diagnosis of hemangioma in a noninvasive manner. Because this is a common finding, this is an important diagnostic algorithm to utilize to diagnose a benign lesion and to separate it from potential malignancy or metastatic disease. In keeping with the recommendation of Drs. Jacoby and DiMarcangelo, I feel that the combination of MRI and ^{99m}TC-red blood cell imaging is clearly confirmed to be clinically useful. □

REFERENCES

1. Freeny PO, Vermont TA: Cavernous hemangioma of the liver; ultrasonography, arteriography, and CT. *Radiology* 132:143, 1979.

2. Front D, Royal HD: Scintigraphy of hepatic hemangiomas: The value of ^{99m}TC-red blood cells. *J Nuc Med 22:684, 1981.*

Dr. Zeiger is a member of our Committee on Publication. He is affiliated with Cooper Hospital/University Medical Center.

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For more information regarding how the Center can help you and your kidney stone patients, call *1-800-542-8887* or *(201) 937-8614*.

New Jersey Kidney Stone Treatment Center

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BOOK REVIEWS

COUGH

Pier Carlo Braga, MD, and Luigi Allegra, MD. New York, NY, Raven Press, 1989. Cough, the most common symptom of pulmonary disease, has not been studied carefully by clinicians, despite a growing awareness of its importance in causing patient discomfort and as an indicator of airway mechanical abnormalities, inflammation, or hyperreactivity; it has been reported to be present in over 100 respiratory and nonrespiratory diseases. This multiauthored volume of 237 pages (3 English and 13 Italian authors) brings together a virtual treasure trove of pertinent information on cough with a useful five-page index and complete annotation of laboratory and clinical references.

The first three chapters discuss the pathophysiology and mechanisms of the cough reflex including its role in whole lung clearance as an adjunct to the mucociliary escalator. This is followed by two chapters on the methodology of study in human and animal models. Following this section is a short discussion on the adverse effects of cough including barotrauma, stroke, and orthopedic complications. The final chapter is divided into four parts and is devoted to symptomatic drug treatment including centrally acting opioid and nonopioid agents and drugs with direct and indirect peripheral action. The antitrussives are discussed in detail with respect to their chemistry, pharmacodynamics, pharmacokinetics, toxicology, and clinical pharmacology. These pages stress that cough has its intensity and patterns vary with the nature and stage of the disease as well as with the type and efficacy of drug treatment.

The book is recommended highly as a reference source for students and house officers but is of great enough significance to be added to the personal library of specialists in lung disease and general medical practitioners as well. This is in recognition of the more than 600 formulations of cough remedies on sale in the United States, many on an over-the-counter basis, and that this class of drugs is the fifth most frequently prescribed. ☐ Monroe S. Karetzky, MD

PHARMACY. AN ILLUSTRATED HISTORY

David L. Cowen, and William H. Helfand. New York, NY, Harry N. Abrams, Inc., 1990. An eminent historian of pharmacy and an internationally respected collector of pharmaceutical art have blended their expertise into a remarkable book. More than 300 illustrations, many of striking beauty, embellish its pages. However, I fear this may be a two-edged sword. Readers may be so dazzled by the graphics that they ignore the text. What a mistake! The writing is exemplary. In clear prose, the authors present an arresting view of pharmacy's evolution from the earliest times when the apothecary invented, prepared, and compounded medicines to modern days when the pharmaceutical industry has supplanted the pharmacist in these traditional roles.

With encyclopedic breadth, Cowen and Helfand cover divers topics from the origin of privately owned pharmacy shops in 8th-century Baghdad, to the increasingly scientific foundation for drug therapy in the 19th century, to the present impact of governmental regulations and the burgeoning pharmaceutical industry on pharmaceutical education. I found the sections on pharmacopoeias particularly enlightening.

Despite its price tag, the authors' intellectual performance and the publisher's exquisite workmanship make this book a bargain. *Pharmacy* will benefit students the most, because it provides a much-needed perspective of their profession at a time when history courses are fast disappearing from the curricula—even as electives—of pharmacy schools. Sadly, today's disciples of Damian, like Dickens's Thomas Gradgrind, are too wrapped up in the latest facts. ☐ Vincent J. Cirillo

TOMORROW'S DOCTORS, THE PATH TO SUCCESSFUL PRACTICE IN THE 1990s

Benjamin H. Natelson, MD. New York, NY, Insight Books/ Plenum Publishing, 1990. Dr. Natelson has produced a highly readable book focusing on what makes a physician a "doctor" and how to go about cultivating the behavior patterns that make a doctor a truly caring, compassionate healer.

In today's medical world, characterized by a fact-oriented school curriculum, the threat of malpractice litigation, and the restraints imposed by a harsh socioeconomic climate, it may be easy to lose sight of the ideals that propelled many of us into this profession. The author redirects our thinking by redefining what it means to be a doctor, and how to achieve the goal of doctor as caregiver and educator.

The book should be "mandatory reading" for medical students, premedical students, and all physicians who wish to become doctors as well. ☐ Alan J. Lippman, MD

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LETTERS AND VIEWPOINTS

HIPPOCRATIC OATH: ANOTHER VIEW

The Hippocratic oath was written 2,500 years ago to guide physicians in their ethical behavior toward patients, colleagues, and teachers. It has stood the test of time and does have "abiding validity" as Mr. Fox asserted in the January 1991 issue of *NEW JERSEY MEDICINE*. Nevertheless, the miraculous advances in medicine and surgery over the past several decades necessitate a fresh look at some of the oath's tenets. The original oath as set forth below bans urologic surgery:

I swear by Apollo Physician and Asclepios and Hygeia and Panacea and all the gods and goddesses, making them my witnesses, that I will fulfill according to my ability and judgment this oath and this covenant:

To hold him who has taught me this art as equal to my parents and to live my life in partnership with him, and if he is in need of money to give him a share of mine, and to regard his offspring as equal to my brothers in male lineage and to teach them this art—if they desire to learn it—without fee and covenant; to give a share of precepts and oral instruction and all the other learning to my sons and to the sons of him who has instructed me and to pupils who have signed the covenant and have taken an oath according to the medical law, but to no one else.

I will apply dietetic measures for the benefit of the sick according to my ability and judgment; I will keep them from harm and injustice.

I will neither give a deadly drug to anybody if asked for it, nor will I make a suggestion to this effect. Similarly I will not give to a woman an abortive remedy. In purity and holiness I will guard my life and my art.

I will not use the knife, not even on sufferers from stone, but will withdraw in favor of such men as are engaged in this work.

Whatever houses I may visit, I will come for the benefit of the sick, remaining free of all intentional injustice, of all mischief, and in particular of sexual relations with both female and male persons, be they free or slaves.

What I may see or hear in the course of the treatment or even outside of the treatment in regard to the life of men, which on no account one must spread abroad, I will keep to myself, holding such things shameful to be spoken about.

If I fulfill this oath and do not violate it, may it be granted to me to enjoy life and art, being honored with fame among all men for all time to come; if I transgress it and swear falsely, may the opposite of all this be my lot. (Translation by Ludwig Edelstein)

In the 11th century, philosopher-physician Maimonides, in his *Book of Precepts*, wrote a "Morning Prayer of the Physician" as a guide for ethical behavior:

O God, let my mind be ever clear and enlightened. By the bedside of the patient let no alien thought deflect it. Let everything that experience and scholarship have taught it be present in it and hinder it not in its tranquil work. For great and noble are those scientific judgments that serve the purpose of preserving the health and lives of Thy creatures.

Keep far from me the delusion that I can accomplish all things. Give me the strength, the will, and the opportunity to amplify my knowledge more and more. Today I can disclose things in my knowledge which yesterday I would not yet have dreamt of, for the Art is great, but the human mind presses on untiringly.

In the patient let me ever see only the man. Thou, All-Bountiful One, hast chosen me to watch over the life and death of Thy creatures. I prepare myself now for my calling. Stand Thou by me in this great task, so that it may prosper. For without Thine aid man prospers not even in the smallest things.

In modern times, UMDNJ President Stanley Bergen, Jr., MD, has had students graduating from New Jersey medical and osteopathic schools recite a modified oath at commencement:

The Oath of Hippocrates

I do solemnly swear by that which I hold most sacred:

That I will be loyal to the profession of medicine and just and generous to its members.

That I will lead my life and practice my art in uprightness and honor.

That into whatsoever house I shall enter it shall be for the good of the sick to the utmost of my power holding myself aloof from wrong, from corruption and from the tempting of others to vice.

That I will exercise my art solely for the care of my patients and will give no drug and perform no operation for a criminal purpose far less suggest it.

That whatsoever I shall see or hear of the lives of men which is not fitting to be spoken. I will keep inviolably secret.

These things I do promise and in proportion as I am faithful to this my oath may happiness and good repute be ever mine and may the opposite if I shall be forsworn.

The Osteopathic Oath

I do hereby affirm my loyalty to the profession I am about to enter.

I will be mindful always of my great responsibility to preserve the health and the life of my patients, to retain their confidence and respect both as a physician and a friend who will guard their secrets with scrupulous honor and fidelity, to perform faithfully my professional duties, to employ only those recognized methods of treatment consistent with good judgment and with my skill and ability, keeping in mind always nature's laws and the body's inherent capacity for recovery.

I will be ever vigilant in aiding in the general welfare of the community, sustaining its laws and institutions, not engaging in those practices which will in any way bring shame

or discredit upon myself or my profession.

I will give no drugs for deadly purposes to any person, though it be asked of me.

I will endeavor to work in accord with my colleagues in a spirit of progressive cooperation, and never by work or by act cast imputations upon them or their rightful practices.

I will look with respect and esteem upon all those who have taught me my art. To my college I will be loyal and strive always for its best interests and for the interests of the students who will come after me.

The oldest medical school in the United States, the University of Pennsylvania, founded 1765, asked their medical school graduating class of 1953, of which I was a member, to take a new oath that updated the ancient principles of Hippocrates to the changes brought about by 20th-century medicine:

Declaration of Geneva

At the time of being admitted as a member of the medical profession:

I solemnly pledge myself to consecrate my life to the service of humanity;

I will give to my teachers the respect and gratitude which is their due;

I will practice my profession with conscience and dignity;

The health of my patient will be my first consideration;

I will respect the secrets which are confided in me, even after the patient has died;

I will maintain by all the means in my power, the honor and the noble traditions of the medical profession;

My colleagues will be my brothers & sisters;

I will not permit considerations of religion, nationality, race, party politics or social standing to intervene between my duty and my patient;

I will maintain the utmost respect for human life (from the time of conception); even under threat, I will not use my medical knowledge contrary to the laws of humanity.

I make these promises solemnly, freely and upon my honor.

[*World Medical Journal* 3 (1956), Supplement, pp. 10-12. Reprinted with the permission of the *World Medical Journal.*]

Whichever oath today's new physician takes, he must combine the science of 20th-century high technology medicine with the age-old traditional art of medicine as a guide to the practice of medicine. As the esteemed Harvard clinician Charles Peabody, MD, so eloquently stated, "The secret of the care of the patient is caring for the patient." □ Ellis P. Singer, MD

HEALTH CARE COSTS

The population has been deluged with information regarding runaway medical costs. Medicare cost overruns are threatening any attempt to balance our budget on a federal level. States are being bankrupted by Medicaid costs as governments shift costs back to them. Doctors are seeing reimbursements cut and are called money gougers by senior citizen groups despite the fact that the fees they can charge senior citizens essentially have been frozen for the past six and one-half years.

I heard from the executive director of the Medical Society of New Jersey that, according to the Federal Budget Office, 65 percent of all Medicare expenditures goes to administrative costs. Only 35 percent goes to pay benefits to patients. When these numbers were questioned, the Library of Congress demonstrated an error. In actuality, 70 percent goes to administrative costs and only 30 percent goes to patients.

Administrative costs include the huge bureaucracy at HCFA in Washington and all district offices. It includes all the independent insurance companies administering the program. It includes all the PROs (professional review organizations) who oversee the program and insure quality care.

I was even more shocked to learn that only 10 percent of Medicaid's dollars go for patient benefits. Ninety percent is eaten up along the way. This information is incredibly shocking. This government is talking about limiting access, and restricting and rationing health care, and all the other factors that many Americans find appalling. It is time for a taxpayer revolt of astronomical proportions. We must band together and demand our legislators pass laws to prevent any more than one-third of the total allocation to health care be permitted in administrative costs. We must insist that at least two-thirds of our tax dollars allocated for health care be spent for health care. This would yield an immediate reduction of 50 percent of total Medicare costs without taking away a single penny of benefits.

Let the damned bureaucrats find another job. Ask any Medicare recipient if they help or do they just muddy up the waters? Some congressmen say we cannot afford the Cadillac of health care and must tighten our belts. But can we afford the Rolls Royce of bureaucracy?

Bureaucrats will claim they prevent abuse of the system and protect quality care. Hospitals already must maintain sophisticated quality of care mechanisms to be approved by the JCAH, the accrediting agency for hospitals. This approval is required by every state and paid for by the hospitals. It is far more efficient than PROs. It does not cost the government a single penny. PROs have reviewed 30,000 cases and delivered two sanctions against physicians, and they are questionable.

It is time to scrap the entire bureaucracy and create a functional health system that concentrates more upon delivery of quality medical care to patients and less about computer printouts, memos, and obtuse regulations that Harvard PhDs cannot comprehend. □ Paul R. Megibow, MD, Secretary, Bergen County Medical Society

MATERNAL MORTALITY

I take some exception to the editorial written by Dr. Abrams

concerning maternal mortality review in the state of New Jersey (87:975-976, 1990).

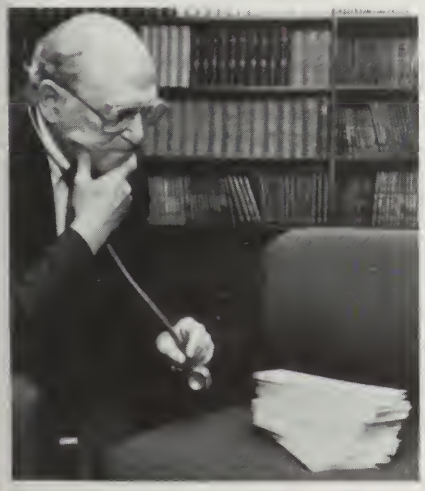
Just as the Medical Society of New Jersey has a Subcommittee on Maternal Mortality, the New Jersey Ob/Gyn Society has a similar committee, and at every meeting of the organization, maternal mortality is discussed in detail and case presentations are made. This is an extremely enlightening and instructive session and brings to the forefront the tragic situation of maternal death. All members present at these meetings are urged to bring this information back to their respective hospitals and medical staffs, and it is my personal belief that many hospitals throughout the state of New Jersey conduct serious maternal mortality reviews.

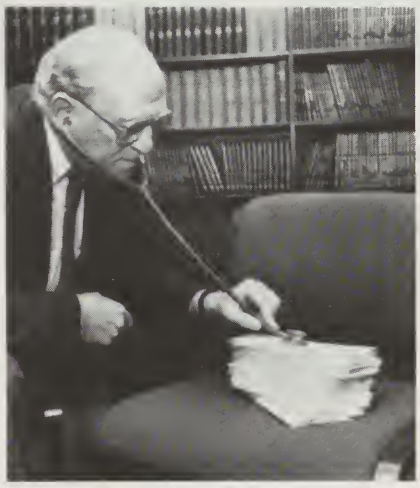
I cannot agree with your conclusions.

Please be assured that the New Jersey Ob/Gyn Society shares your concern about maternal mortality and for many years has undertaken the study of maternal mortality as one of its primary educational duties. ☐ John S. Garra, MD, President, New Jersey Ob/Gyn Society

PRACTICING MEDICINE

In a series of three photographs, Frank J. Malta, MD, internist, attempts to examine the "invisible patient" that has been introduced in recent years as a result of third-party payor's involvement in the practice of medicine.







In the photographs, the stack of letters represents one month's correspondence from home health agencies under Medicare that required opening, review, comments, signature, and return mail to the home health agencies. It required one hour of the physician's personal time to respond to these letters. This correspondence is a fraction of the paperwork that continues to arrive on a regular basis as a result primarily of Medicare, as well as other third-party health insurance payors. ☐ Frank J. Malta, MD

SYNDROME LISTINGS

When does a syndrome become a recognized entity? Is the answer, "By a new turn of events?" or is the answer, "When Medicare recognizes it?" Both seriously and humorously, I call attention to a new status of titles in the publication of *ICD-9 CM, Volume 2*. This volume lists over 1,000 syndromes by name. What becomes of those syndromes omitted? This means Young's syndrome (bronchiectasis, sinusitis, and cysts of the epididymis) would be a problem in processing because it has no listing, although a significant percentage of men with Young's syndrome are sterile and need study of both respiratory tract and gonads. Young's syndrome is listed in *Dorland's Medical Dictionary* (1988 edition) within 18 pages of syndromes, and it is listed as Barry-Perkins-Young syndrome ("synonyms: Young's; azoospermia, obstructive, sinopulmonary infections; sinusitis-infertility") in the *Dictionary of Medical Syndromes*.

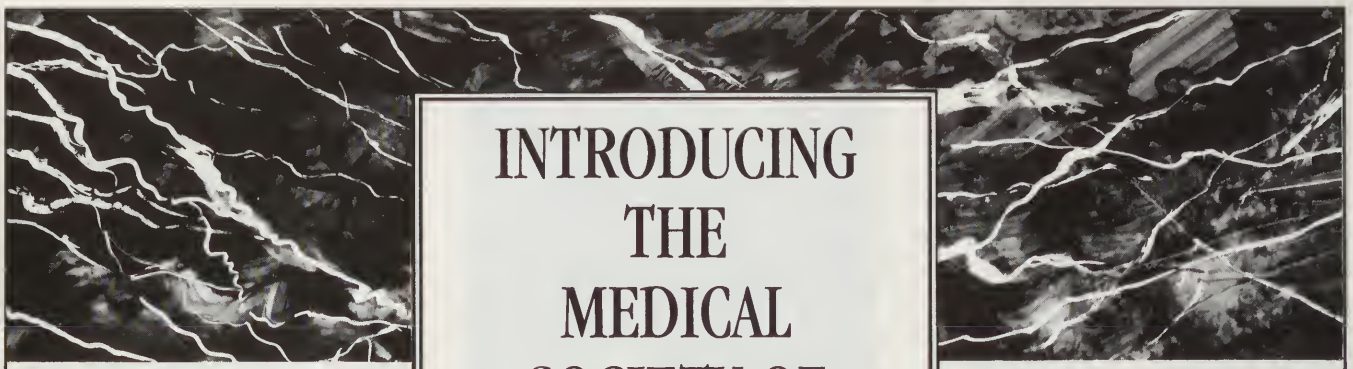
Young's syndrome also is recognized by an article in *The New England Journal of Medicine* (January 5, 1984) with 34 references, some relating it to cystic fibrosis, immotile cilia, and vasectomy.

On the cheerful side, to teachers of house staffs and CME chairmen, these syndrome pages provide a perfect subject for the few minutes when the speaker is late in getting started. Let's use them!

For example, the chairman can be prepared to present ten syndromes or so to fill in the time constructively, as not-so-trivia questions to the audience. It will take many months to go through this list of "selected short subjects," and house staff or postgraduate time will not be wasted, learning thereby what is both medically curious and perhaps someday payable. ☐ Morris Soled, MD

LETTERS TO THE EDITOR

The editor-in-chief welcomes all letters and viewpoints on topics of interest to the Medical Society of New Jersey, and to all physicians in the state. Letters should be sent to the Medical Society of New Jersey, Two Princess Road, Lawrenceville, NJ 08648.



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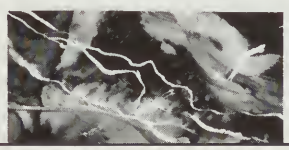
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ROBERT McKEAN AND THE MEDICAL SOCIETY OF NEW JERSEY

Geraldine Hutner, MA

The Medical Society of New Jersey, the oldest such society in the United States, elected the Rev. Mr. Robert McKean as its first president in July 1766. Robert McKean was a clergyman and physician, and his untimely death was the end of a brilliant career.

Robert McKean's grandmother, Susannah McCain, settled her family on 300 acres of land in Chester County, Pennsylvania, in 1725. She died six years later in the winter of 1731. Susannah wrote her will two months before her death, leaving property and valuables to her children: William, Thomas, Barbara Murrah, John Craghton, Margaret, and James.[1]

FAMILY HISTORY

The eldest of the six children, William McCain (1708-1769) married Letitia Finney, daughter of Robert and Dorothea Finney. William and Letitia, and their four children, Robert, Thomas, Dorothea, and William, operated an inn in what today is Chatham, Pennsylvania; in 1741, the McKeans [spelling change] moved to Londongrove, an adjoining township, to sell "beer and syder."

EARLY EDUCATION

William and Letitia's first child, Robert, was born on July 13, 1732, in Chester County. By the age of ten, Robert and his eight-year-old brother Thomas already "learned reading, writing, and arithmetic . . . and were better educated than most, if not all, of their McKean aunts and uncles, and they must have received much of this training from their mother."[2] Shortly before Letitia's death in 1742, Robert convinced his parents to allow him to study medicine and theology, and upon his mother's death, Robert and Thomas were sent to Reverend Francis Alison, a noted Presbyterian minister in Philadelphia.[3]

Francis Alison (1705-1779) was a well-known scholar and headmaster of a prestigious Philadelphia academy.[4,5] Highly regarded for his "unusual fund of learning and knowledge which fitted him for the painful instruction of youth,"[4] Alison was reported to be "frank, open, and ingenuous in his natural temper . . . blessed with a clear understanding and an extensive liberal education, thirsting for knowledge.[5]

Upon arrival at Alison's New London Academy,[7] the brothers would learn languages, the practical branches of mathematics, rhetoric, logic, and moral philosophy.[2] From his studies with Alison, Robert and Thomas "acquired an unusual knowledge of Greek and Latin, and carefully read the works of the Anglican divines."[3] After seven years of disciplined education, Robert and Thomas left New London Academy in 1751; they moved to Philadelphia where Robert studied "physick" with Thomas Cadwalader and Thomas studied law with his cousin.[2]

ORDINATION

Thomas and his friends persuaded Robert to study abroad and then convinced him to become an Anglican: "Robert was ambitious and practical in the same way; when the opportunity arose to further his true calling as a physician through the vocation of the ministry, he switched from the Presbyterian to the Anglican Church, as the latter required training in England. There, not incidentally, he obtained medical training as well."[2] One of Thomas's friends, Francis Hopkinson, a devout Anglican, might have been one of the guiding forces behind Robert's conversion. And, this conversion



Figure 1. Seal of the Society for the Propagation of the Gospel.

could have appealed to Robert's practical side as it was known that "the Society for the Propagation of the Gospel (SPG) in Foreign Parts [also known as the Venerable Society] often paid the transportation costs of young Americans seeking ordination in the Church of England." (Figure 1).[2]

While studying theology, Robert "furthered his medical studies by taking advanced courses in anatomy with Dr. Hunter and midwifery with Dr. Smellie."[2] McKean applied to the Bishop of London for holy orders and was ordained to the priesthood of the Anglican Church receiving his license on April 26, 1757. One of his recommendations came from James Stirling: Robert "was a young man of exemplary merit."[3] With papers in hand and Thomas's good wishes (Figure 2), Robert was appointed by SPG to Christ Church in New Brunswick.

SPG was chartered on June 16, 1701, by King William III. The organization flourished under Queen Anne, and many Anglican parishes in North America owe their origins to this group. SPG came to a close in the American colonies at the time of the American Revolution, but the institutions it established continued their mission, including 19 churches in New Jersey.[8,9]

FIRST ASSIGNMENT

It was usual for the clergy in the middle and southern American colonies to be college educated at European institutions. Churches in the states mainly were Anglican, and an Anglican "parish frequently covered half a county and that the clergyman served more than one church at a time."[10]

On December 16, 1757, an eager and young McKean arrived at a brownstone building on Church and Neilson Streets. Built in 1743 in the Gothic Revival style, Christ Church was one of the first of its denomination in the United States. Like his two Christ Church predecessors, McKean was a minister and a physician, and it was recorded that SPG "sent out many missionaries who were physicians as well as priests because there were as few of the former as of the latter in the colonies. But the combination worked badly, partly due to conflict of duties and partly due to disturbances in the pastoral relationship over doctor's bills."[11]

In 1760, Robert and two other Anglican clergymen welcomed the new royal governor of New Jersey. As all Anglican clergymen were required to take an oath of allegiance to the King, Robert and his peers sent a message to the new governor expressing congratulations on his appointment and "their sense of obligation to contribute in every way possible to the tranquility and harmony of the state"; they continued, "We are encouraged to believe that we shall receive the same Favour, Countenance, and Protection [as in the past].' "[2] Robert now was a member of the established church and was well accepted and acknowledged for his work.

THE ANTILL FAMILY

Though busy with his responsibilities as physician and pastor, Robert wrote a letter to the SPG offices dated April 15, 1761: "One circumstance respected myself, I can not resist an inclination I have of telling you. I have Sir, changed my condition in life, being happily married about two months ago to the daughter of one of my parishioners." Robert and Isabel Graham Antill were married on February 19, 1761, at Christ Church in Shrewsbury. Isabel, the daughter of Anne Morris and Edward Antill, 2nd, a prominent Anglican layman, was known to have a "very gay and independent spirit."[12]

Edward Antill, 2nd (1701-1770), was a successful merchant and farmer—with over 370 acres of timber and apple orchards. Edward and his second wife, Anne Morris (daughter of Governor Lewis Morris), built their home at Piscataway Landing, on the Raritan River in 1739, on land Edward inherited from his father.[13] [The Antill-McKean home eventually was purchased by a Dr. Alexander Ross in 1772 who gave the home its familiar name—Ross Hall.[15]] It was not business that possessed Edward, but "the cause of religion and education found Edward a valuable supporter . . . He was one of the warmest friends of Christ Church, New Brunswick, and in 1759 was one of the trustees of a lottery for raising 1500 Pieces of Eight to be applied to the use and finishing of that church."[13]

Upon his arrival at the Church, McKean reported to SPG that the

Table. The number of known physicians in New Jersey in 1776.

County	*Population*	*No. of Physicians*
Bergen	9,350	2
Burlington	15,801	6
Cape May	2,281	1
Cumberland	6,300	5
Essex	13,430	14
Gloucester	10,689	4
Hunterdon	18,363	7
Middlesex	12,005	14
Monmouth	14,705	12
Morris	12,416	9
Salem	8,473	3
Somerset	10,476	7
Sussex	14,187	1

"Honorable Edward Antill, a man of most exemplary life, and singular piety, had undertaken to read prayers and a sermon every two Sundays at Brunswick, and every other two at Piscataway, till the arrival of a missionary."[13]

After their marriage, Robert and Isabel lived at Ross Hall (cover) in Piscataway with Edward and Anne; the McKeans had no children.[13,14] Isabel, one of six children, the second youngest in the family, had a strong and loving relationship with her parents and letters record a warm bond existing between Robert and Edward.[14]

PHYSICIAN AND PRIEST

During McKean's rectorship, the charter for Christ Church was granted (November 1, 1761), under the royal authority of King George III.[14] And, while at Christ Church, Robert organized a lottery to help complete the building. During these years, Robert was awarded honorary masters degrees from the College of Philadelphia (now the University of Pennsylvania) in 1760 and from Kings College (now Columbia University) in 1762.[12]

During his tenure at Christ Church, McKean also worked as a "medical missionary in New Brunswick and surrounding communities, combining medicine with his parochial duties for the purpose, primarily, of winning people for his church."[2] Church records noted McKean's medical practice and he was criticized for it: "A man of as much goodness as we could expect, yet we saw bad effects arising from his practice, and we feared that the peace of our church might be effected (sic) by it."[3] But his Church audience continued to grow, and it appears his reputation as a good doctor was enhanced by his Church responsibilities.

McKean's acceptance of Anglican doctrine (a far cry from Alison and his Presbyterian concepts) again was shown in his November 1761 public appearance at ceremonies for another royal governor. One of six clergymen chosen to greet Governor Thomas Boone, McKean and his colleagues issued a welcoming statement: "The church of England, always faithful and steady in their attachments to our admirable form of government, cannot fail of your excellency's protection, and support in all her privileges: And we presume to engage to your Excellency, that we will on our part, agreeably to our sacred obligations, constantly inculcate loyalty to our good and glorious sovereign, and the most ardent affection for our happy constitution, while at the same time we shall do everything in our power to contribute to the ease and honour of your Excellency's administration."[2]

Soon after his marriage, Robert fell ill. It was reported that a "fit of sickness interrupted his pastoral duties for a short time and later a violent epidemical cold laid him low for four weeks."[3] To the untrained eye, it appeared that McKean was on the road to recovery, but that was not to be: his diagnosis was phthisis pulmonalis.[16,17]

After two years of married life, Isabel and Robert moved to Perth Amboy, when Robert accepted the rectorship of Saint Peter's Church and Trinity Church in Woodbridge. Upon leaving, the congregation of Christ Church wrote: "A gentleman whose simplicity of manners, whose gentle, mild and charitable disposition, and who innocent life, have rendered him dear to us, and amiable to men of all denominations; we can't but express our great concern at such a loss, which we very much fear will hardly be repaired."[3] After his departure, his father-in-law, Edward, read prayers and sermons until the arrival of Reverend Leonard Cutting (1724-1794).

ST. PETER'S CHURCH

Perth Amboy flourished during the Colonial period.[17] The townspeople noted this golden age: "Perth Amboy was on the main highway and thoroughfare between New York and Philadelphia. Through this place the people of the country passed."[12] St. Peter's Church played an important part in the growth of the community: the church "was the established religion of the place."[12] Into this haven came Robert, to serve as rector of this Church, founded in 1702, at Rector and Gordon Streets. Appointed to St. Peter's on February 9, 1763, Robert did not move into the parsonage until May 17 of that year; it was noted that the church "was in a very ruinous condition, but that there was a fund to repair it."[12]

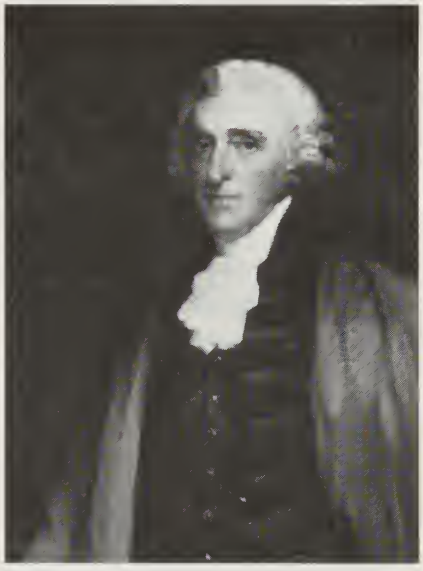


Figure 2. Thomas McKean, Robert's younger brother and a governor of Pennsylvania. ©The University of Pennsylvania Archives.

The oldest Episcopal parish in New Jersey, St. Peter's Church was "a well-compacted building of stone and brick" built in 1719 (Figure 3).[11] The building, in the Gothic Revival style, was erected on land donated by respected townspeople. Robert was well received by the local parishioners; he was noted to be an able and zealous young clergyman (Figure 4). By 1764, McKean noted that "two-thirds of the inhabitants of [Perth Amboy]" attend his Church; the rest being Presbyterians and a few Quakers.[12]

In addition to his work at St.

Peter's Church, McKean served other parishes; in a letter to SPG, dated September 10, 1763, McKean wrote he "agreed to give one-third of his time to Woodbridge, and two-thirds to Perth Amboy which division of labor he flatters himself will give satisfaction."[12] And he continued to spread his work, with new duties at churches he helped build in Spotswood and South River.[12]

McKean served as physician and pastor to his community, and in July 1765, he added another responsibility by becoming schoolmaster in Perth Amboy: "A schoolhouse adjacent to the church was built."[9]

TRINITY CHURCH

In 1763, Robert became the new pastor for Trinity Church (founded in 1698) in Woodbridge,[9,18] dividing his time between Trinity Church and St. Peter's Church. His letters to SPG indicated his pleasure with his work in this small parish of 12 families, 14 communicants, and 50 persons, and the community felt Mr. McKean was "a young priest of brilliant promise."[19]

FIRST SIGN OF ILLNESS

McKean wrote a letter to SPG on October 25, 1765, noting his serious illness: "I was seized with a very tedious and dangerous sickness that rendered me entirely incapable of any business for about three months."[20] With a trained eye and diagnosis of phthisis pulmonalis, Robert sought medical care from Dr. John Morgan of Philadelphia (Figure 5).[20]

Physician, surgeon, and educator John Morgan (1735-1789) was born in Philadelphia and attended Reverend Finley's Nottingham Academy. He was awarded his A.B. degree from the College of Philadelphia in 1757 and then became a medical apprentice to John Redman. In 1760, Morgan studied medicine in London and Edinburgh and was awarded a medical degree from the University of Edinburgh in 1763.

After postgraduate training in Paris and Italy, he returned to Philadelphia to practice medicine in 1765 and was affiliated with the College of Philadelphia. It was at this time that McKean contacted Morgan for medical advice. Morgan had a distinguished career that included: director-general of hospitals and physician-in-chief of the Continental Army; senior medical officer for Pennsylvania Hospital; and founder of the first medical school in the United States, the University of Pennsylvania School of Medicine.

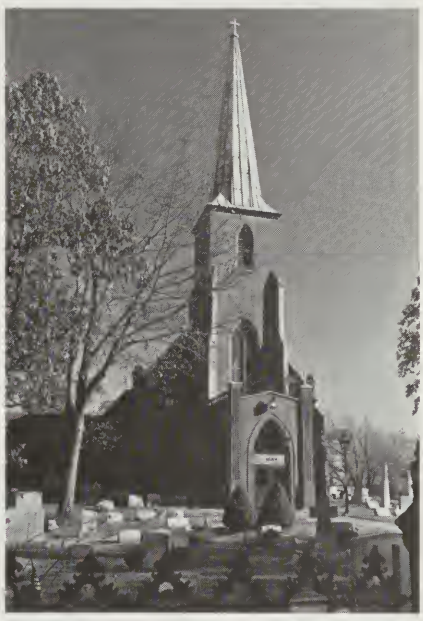


Figure 3. St. Peter's Church. ©Spud Grammar.

Dr. Morgan wrote a case report to McKean recorded by Dr. Jonathan Elmer, Morgan's apprentice:

> That your disorder is a true phthisis pulmonalis appears evident to me, but I think it is not yet so far advanced but that it may admit to a radical cure; if we are so happy as to agree upon a proper plan of treatment, which is the thing now to be considered. Let us then take our Indications from the present state of your lungs & strength of body. The fever & pain with the night sweats & difficult respiration, together with the violence & duration of the disease, the troublesome cough & the present ulceration of the Lungs are to give us light in this matter. These declare a very general & hitherto a very fixed obstruction in the viscus. The sweats arise from the absorption of Pus into the Blood, as is plain from the decrease of this symptom since an expectoration came on. That these are Tubercles in the Lungs is highly probably from that constant irritation to cough, & from this consideration that inspection has invariably demonstrated the existence of tubercles in every similar complaint so violent & so long continued. The strength of the body must be greatly impaired from every concurring circumstance.[20]

Dr. Morgan continued his report, with a two-page plan of treatment, ending with the words: "But above all a free & temperate Air is necessary throughout the whole of the disorder, therefore get out as often as you can. If you or other gentlemen who may be advised in the case approve of the above, it will be easy to improve these hints into proper formula."[20]

FOUNDING OF MSNJ

Even with illness, Robert continued his work; he received honors and praise at every occasion. Yet, the greatest contributions "during his last years, were to the medical professional, as organizer and first president of the Medical Society of New Jersey."[2]

"The practice of medicine in colonial times had more breadth than depth, and the clergy who were among the best educated members of the community often had to care for both the bodies and souls of their parishioners. In the 18th century, an era rife with epidemic disease, the local parson frequently was called upon to minister and prescribe for his charges who were sick."[9] It has been recorded that as a physician, Robert McKean practiced in many areas of Middlesex County.

By 1776, approximately 85 physicians (Table) practiced in New Jersey (for the 148,652 citizens), and with Middlesex County considered a "hub of commerce and travel," it was a perfect meeting place for these professionals.[21,22] So, on June 27, 1766, a notice (Figure 6) appeared in the *New York Mercury* newspaper requesting physicians to gather at Duff's Tavern to es-

tablish a society for the advancement of their profession: "A considerable number of the practitioners of physic and surgery having agreed to form a Society for their mutual Improvement, the Advancement of the Profession, and the Promotion of Public Good:—and desirous of extending as much as possible, the Usefulness of their Scheme, and of cultivating the utmost Harmony and Friendship with their Brethren, hereby request and invite every Gentleman of the Profession in the Province, that may approve of the Design, to attend their first Meeting."[20]

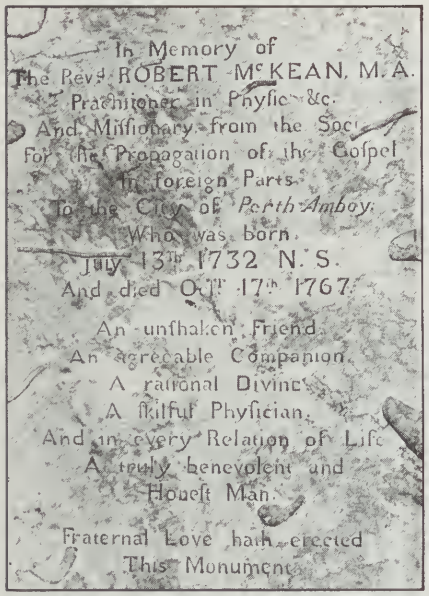


Figure 4. Monument at St. Peter's Church written by Thomas McKean.

Seventeen men met on Wednesday, July 23, 1766, in New Brunswick, and elected McKean, age 34, the Society's first president. McKean signed the "Instruments of Association and Constitutions and the Table of Fees and Rates" as established and approved by the 17 founders of the first state medical society in the United States. The members "formulated the principles and ideals of the medical profession, and separated the functions of the doctor from those of the priest, the druggist, or the family friend. This group also distinguished between well-trained practitioners and the peripatetic quacks, who set themselves up as doctors of medicine."[2,23]

Though unable to attend the second meeting, held on November 4, 1766, McKean sent correspondence to be read to the attendees. At the Society's third meeting on May 5, 1767, held in Perth Amboy, Robert was reelected as president of the Medical Society of New Jersey on May 5, 1767—four months before his death.

BEGINNING OF THE END

The tuberculosis progressed and McKean fell ill soon after his election. Thomas B. Chandler, a local judge, wrote that Robert was "wasted away with a tedious disorder, the worthy, the eminently useful and amiable Mr. McKean is judged by his physicians to be present at the point of death."[3,25] On September 13, 1767, Robert wrote his will, probably aware of his condition:

To my father, William McKean, &10. My brother-in-law, Richard Cochran, &20. Wife, Isabel, 1/2 of the rest. To my little nephew, Robert McKean, son of my brother Thomas, of the town and Co. of Newcastle, Delaware; my brother, Thomas, and brother, William; and my only sister, Dorothea Thompson, wife of John Thompson, the rest. Executors—brother, Thomas, and my brother-in-law, Richard Cochran. Witnesses—Gannata Harrison, Lewis Antil, Thomas McKean.[16]

IN MEMORIAM

At age 35, Robert died of pulmonary tuberculosis at Ross Hall, Raritan Landing, near New Brunswick, on October 17, 1767. Robert McKean was buried in St. Peter's Church, Perth Amboy, where his brother, Thomas, signer of the Declaration of Independence and governor of Pennsylvania, erected a monument (Figure 4).

In Memory of the Rev. Robert McKean, M.A., Practitioner in Physic, &c, And Missionary from the Society for the Propagation of the Gospel in Foreign Parts, To The City of Perth Amboy, Who was Born, July 13th, 1732, N.S., And died October 17th, 1767. An unshaken Friend, an agreeable Companion, a rational Divine, a skillful Physician, and



Figure 5. John Morgan, Robert McKean's physician. ©The University of Pennsylvania Archives.

in every Relation of Life, A truly Benevolent and Honest man.[2,7,20]

Eighty years after his death, the Medical Society of New Jersey paid tribute[26] to the Reverend Dr. Robert McKean:

This union [Robert was a physician and a clergyman] has the sanction of the high example of the founder of our religion who, while preaching the Gospel to the poor, also healed the sick; and many missionaries of recent times, have often found a knowledge of the medical art of great service to them, in the fulfillment of the duties of their higher and more important calling. The hours of sickness and sorrow, when the heart is softened, and the thoughts weaned for a time, from the world, afford the best opportunities for religious counsel and instruction. The physician will be admitted and listened to, when the clergyman may be shut out or repulsed. . . . The physician, in his daily conflicts with peevishness and pain, and disease, and misery; in his frequent exposure to danger and death from contagion and infection; in his manifold trials of body, mind, and spirit, needs other support than earthly motives; other consolations than worldly gains; in a strong religious faith, he has a support for himself, and a power which may often be most happily employed in controlling disease, or when the resources of his art fail, in cheering sufferers, by throwing the light of hope on the passage to the grave. Without strong religious convictions, the physician, from witnessing so much of the ills of life, is apt to sink into the careless, easy-tempered sensualist, or harden into the cold, scoffing materialist. . . . Dr. McKean lived but a short time after the

formation of the Society . . . leaving behind him an excellent character in both the professions in which he was engaged. While the members of our Society may congratulate themselves in having such a man for their first president, may they prove to the world that he is a fair representative of the character of the profession.

On the 225th anniversary of St. Peter's Church in Perth Amboy, the Medical Society of New Jersey honored Robert McKean by erecting a tablet, with an inscription and seal, in the sanctuary to his memory. In his address dedication, Wells P. Eagleton, MD, memorialized McKean "because he formed a society for mutual improvement, the advancement of the profession, the promotion of the public good, and the invitation to all the gentlemen of the profession who approved of these principles to join."[27] The words of W. Barlow pay the highest tribute to Robert McKean: "Promoted zealously the science of medicine and played an important role in establishing professional standards for physicians."[28] ■

Ms. Hutner is executive editor of *NEW JERSEY MEDICINE.*

On the cover. Ross Hall was home to MSNJ's first president, Rev. Robert McKean. Built in 1741 by Dr. Edward Antill, McKean's father-in-law, the house was razed in the 1950s. It was a large Dutch colonial-style farmhouse, wider than it was deep, with a gambrel roof and Greek Revival porch. The foundation was dug into the south-facing bluff above the flood plain of the Raritan River where the Continental Army was encamped in the summer of 1778.

A Conſiderable Number of the Practitioners of Phyſic and Surgery, in Eaſt-New-Jerſey, having agreed to form a Society for their mutual Improvement, the Advancement of the Profeſſion, and the Promotion of the Public Good :---And deſirous of extending as much as poſſible, the Uſefulneſs of their Scheme, and of cultivating the utmoſt Harmony and Friendſhip with their Brethren, hereby requeſt and invite every Gentleman of the Profeſſion in the Province, that may approve of their Deſign, to attend their firſt Meeting, which will be held at Mr. Duff's, in the City of New-Brunſwick, on Wedneſday the 23d of July, at which Time and Place the Conſtitutions, and Regulations of the Society are to be ſettled and ſubſcribed.

Eaſt New-Jerſey, June 27, 1766.

Figure 6. Notice from the *New York Mercury,* announcing the first meeting of the Medical Society of New Jersey.

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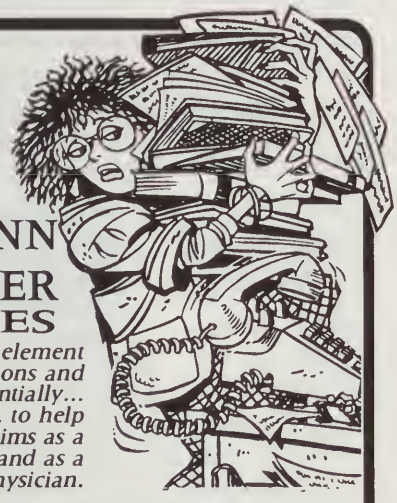
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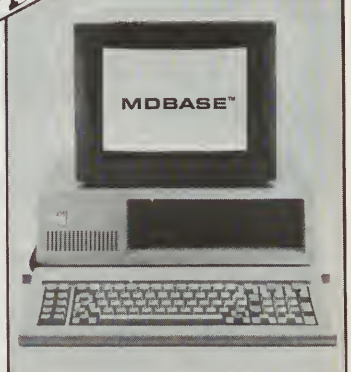
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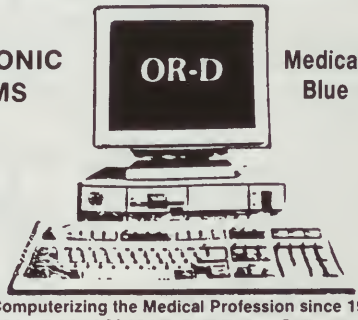
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PASSING A MEDICAL WASTE INSPECTION

John LaCarrubba

How would your office do at a medical waste inspection? Would an oversight result in a notice of violation? Is your office keeping up to date with its tracking and logging forms? This article highlights the areas that need periodic attention regarding medical waste laws in New Jersey.

The New Jersey State Department of Environmental Protection (DEP), on June 22, 1989, adopted NJAC 7:26-3A, an emergency rule that significantly impacts the manner in which seven classes of medical waste must be managed. The law further empowers the United States Environmental Protection Agency, the New Jersey State Department of Health, and the New Jersey State Department of Environmental Protection to enter (during normal working hours) the offices of those to whom the law applies and conduct an inspection of the documentation and procedures governed by the regulated medical waste (RMW) laws. These inspections may be by appointment or made extemporaneously by an inspector working in a particular area that day.

How would your office do at such an inspection? Will an oversight in paperwork or procedure result in a notice of violation? Will your name and/or practice appear in the newspaper, as it has to others, publishing the charges pressed or fines levied?

The following article highlights those areas that need periodic attention and cause most of the medical waste violations issued. Should you have any questions regarding the medical waste laws or would like to obtain the RMW generator and/or tracking form fact sheet, call the DEP Medical Waste Program at 609/530-8599.

REGISTRATION

The medical waste generator registration year runs from July 22 to July 21. If your business generated any RMW between June 22, 1989, and June 21, 1990, you already should have registered with DEP as a generator of medical waste, regardless of the amount of RMW generated. Registration fees were due by August 20, 1990. After July 21, 1990, you will be paying for the 1990-1991 year; however, you also will receive a second billing for the 1989-1990 year. While belatedly paying the 1989-1990 fee evens the financial score with the DEP, you are subject up to a $10,000 fine for not having registered during that year.

Do not let the specter of the possibility of this fine being levied prevent you from registering. If left unattended, continued nonregistration will place your practice in an ever-increasing untenable position. The latest registration fees are weight based for each generator site and are $100 per year for generating 50 or less pounds of medical waste per year; $300 for 50 to 200 pounds per year; $500 for 200 to 300 pounds per year; $1,000 for 300 to 1,000 pounds per year and $3,500 for greater than 1,000 pounds per year.

Retain copies of your registration application, both sides of your cancelled check, and the notice listing your seven-digit generator registration number.

DAILY/MONTHLY LOGS

If your office generates more than 300 pounds of medical waste per year, you must keep a daily log of the medical waste generated. If less than 300 pounds per year are generated, you are required to maintain a monthly log. The latest, revised log forms were sent to those generators who also received the annual generators' report form. These log forms, with their instruction booklets, are available from DEP, Bureau of Special Waste Planning, 840 Bear Tavern Road, CN 414, Trenton, NJ 08625, or by calling 609/530-8599. The same form is used for the daily or monthly log; the generator needs to make sufficient copies.

The daily log should be completed at the end of each day, or at beginning of the next day, prior to the start of business. Monthly logs should be com-

pleted on the last day of the calendar month, or as soon as possible thereafter. It is important to note the day or month that is being logged. These logs are not to be mailed to DEP. They are to remain at the point of generation for at least three years unless the DEP specifically requires an additional retention period. Should any paperwork be involved in any legal action, it must be kept until the action is closed.

Care must be taken when completing these log forms since each waste class has several options regarding treatment and disposal. Furthermore, caution is advised when logging less than a pound of waste. If it is less than one pound, you might want to use a fraction versus a decimal. If you are logging in ounces, make sure it is very clear that the measure is in ounces, not pounds.

The following illustration is an example of how to correctly complete the daily/monthly log: A generator is disposing of waste in sharps containers without sterilizing, disinfecting, or otherwise treating the waste. Once the receptacle or container is filled, the generator calls for a pick up or the transporter has the generator scheduled for pick up. In either case, this would result in the waste class weights being entered on the log form under the Class 4 (sharps), item d, "untreated onsite, shipped offsite" section.

It is important to keep track of each type of waste generated and maintain accurate logs, regardless of the miniscule amount of waste you may generate in specific classes. If you are not sure whether a particular item is considered RMW, call DEP.

TRACKING FORMS

The New Jersey medical waste regulations require all medical waste generators, transporters, intermediate handlers, and destination facilities to track RMW, no matter how small the amount generated.

Each generator shipping RMW off-site is responsible for initiating the tracking form. Each person in the chain of custody (handling process) of RMW assumes the responsibility for getting the waste to the proper destination facility for treatment, destruction, or disposal. Portions of the tracking form must be completed by the RMW generators, transporters, or intermediate handlers, and by destination or disposal facilities.

However, RMW generated in New Jersey but transported for disposal to another state participating in the federal medical waste demonstration program and that prints and requires use of its own tracking form, must be reported on that state's tracking form.

NJ TRACKING FORM

Each New Jersey tracking form contains four copies to be distributed: Copy 4 (goldenrod)—generator copy, retained by generator; Copy 3 (pink)—transporter copy, retained by transporter; Copy 2 (yellow)—disposal facility copy, retained by disposal facility owner/operator; and Copy 1 (white)—generator copy, mailed by disposal facility back to generator.

Once your medical waste is picked up, a tracking form is completed and signed by you and the transporter. You are left with Copy 4. In the simplest of situations, your transporter takes your medical waste to the destination facility without the use of an intermediate transporter. Once at the destination facility, the remaining three parts of the tracking form are signed by the destination facility and the transporter keeps one copy. Copy 1 (with original signatures) is sent by the destination facility to the generator. You should have two copies of the tracking form for each transaction. This establishes the cradle-to-grave tracking described in the emergency rule. (Tracking forms are available free of charge from the New Jersey State Bureau of Special Waste Planning.)

Once Copy 1 is received from the destination facility, it should be attached to the corresponding Copy 4 and placed in the file with the daily/monthly logs. Should the generator not receive Copy 1 within 35 days, a documented attempt must be made to rectify this paperwork problem. The generator should turn to the transporter to solve the problem. If the situation is not corrected within 10 days, it is the generator's responsibility to file a discrepancy report to EPA and NJDEP. Generators are responsible for the accuracy of the information in boxes 1 to 15 on the tracking form.

It is of paramount importance to understand that the generator is responsible for maintaining complete and accurate paperwork and documentation.

There are some generators who continue to use a mail-away program for their sharps. To insure you are complying with regulations, you can only mail Class 4 and Class 7 RMW using registered mail by United States Postal Service, e.g. not Federal Express or UPS, and obtain a return receipt. The generator must provide and complete a New Jersey tracking form and send this form with the shipment. The company to whom the waste is mailed must return the tracking form to the generator after signing as transporter or intermediate handler if it is using a destination facility other than itself; if it is a destination facility, then it completes the destination facility section.

If a mail-away program or a medical waste transporter refuses to complete a New Jersey tracking form, change companies. It is the generator's responsibility to insure there is a tracking form for each medical waste transaction, and it will be the generator's liability if a shipment of medical waste is not documented by a New Jersey tracking form. Some transporters will complete tracking forms for you and only require your signature at the time

of servicing; however, each generator is responsible for the accuracy of the information entered on the form.

GENERATOR REPORT

At the end of the first medical waste reporting year (June 22, 1989, to June 21, 1990), DEP sent information verification sheets, annual reports, and the revised daily/monthly logs to registered generators. The annual report was to be completed by the generator and sent back to DEP within ten days of receipt.

Generators were to review the items on the information sheets including the name of the business, address, telephone number, contact person, and Standard Industrial Classification number. Should any information be incorrect, it should have been corrected and a copy of the sheet was to accompany the original of the annual report sent to the DEP.

The annual report is both an information gathering tool and a compilation of the data from the daily/monthly reports for the reporting period. The information collected by the annual report will be used by DEP in policy determinations. Remember that this first annual generator report only reflects the generator's situation for the reporting period from June 22, 1989, to June 21, 1990.

INFORMATION BINDER

You can organize the maze of medical waste paperwork by using a binder with sections for daily/monthly logs, tracking forms, annual reports, and miscellaneous medical waste correspondence, e.g. discrepancy reports, transporter contracts. Compliance then becomes a matter of maintaining the logs and periodically reviewing the paperwork.

At the time of an inspection, the binder will have all your medical waste information, easing the inspector's task of reviewing the paperwork and your task of trying to retrieve scattered information.

MISCELLANEOUS ISSUES

There are some areas that have been unclear; these may affect your discussion during an inspection.

1. An item becomes medical waste only when the practitioner or health care worker determines that it has outlived its usefulness and must be discarded.

2. The vast majority of medical waste generators produce very small quantities of medical waste, that has caused some dissension on the applicability of the laws. New Jersey's medical waste laws do not provide small quantity generator exemption; therefore, producing ounces of medical waste requires the same attention to paperwork as if hundreds of pounds were generated.

3. Everything in an examining or treatment room is not regulated medical waste. Further, not everything that comes into contact with patients is RMW.

4. New Jersey does not require monthly (or periodic) pickups. Generators may store regulated medical waste as long as it is accessible only to appropriate personnel, is protected from being damaged, and remains nonputrescent. If outside, it also must be kept locked and protected from the weather, vermin, and pests. Engaging a transporter to provide on-call service may more closely meet your needs.

5. No matter how little RMW a practice generates, logs must be kept and annual report forms completed.

6. It is the responsibility of the generator to ensure its medical waste transporter has a current DEP transporter registration number, a certificate of public necessity and convenience from the New Jersey Board of Public Utilities, and a United States EPA registration number. All medical waste transporters must register with the DEP every April. A call to DEP in April or May can determine whether your transporter has registered for that year. Should your transporter not have the required authorization to operate, you will need to change companies.

7. Some counties in New Jersey have requirements to regulate medical waste not included in the state law. This waste should be segregated, listed on the daily/monthly log forms in Section 3, Over-Classified Material, as medical waste mixed with RMW or not mixed with RMW. The grouping together of nonregulated medical waste with RMW when classifying generated medical waste is considered overclassification. The weight of the medical waste associated with a county specific rule should not be included in the generator's projection of the amount of RMW generated in a year. County requirements should not be allowed to cause a generator to go from one weight class to another and incur additional DEP registration fees.

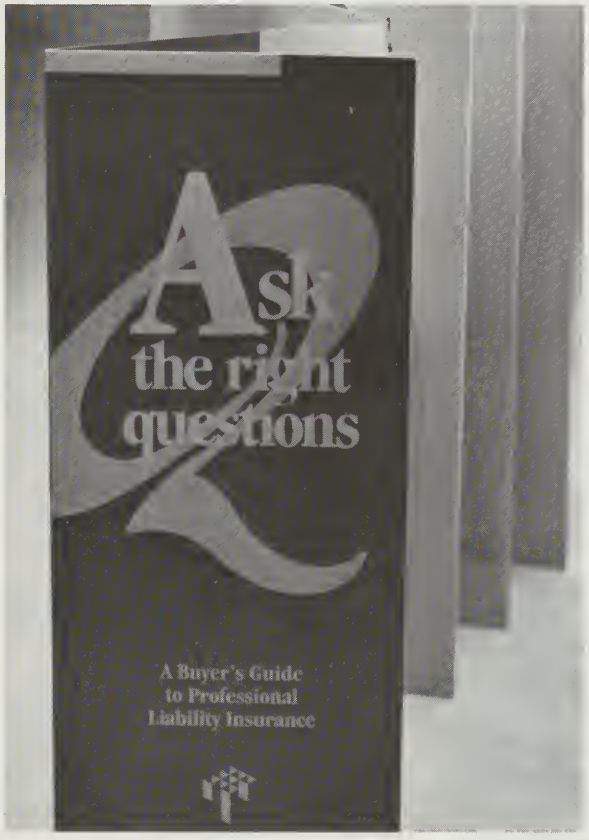
It is best to have one person, most familiar with the paperwork and how the practice complies with the medical waste law, escort the inspector around.

CONCLUSION

Proper management with completed paperwork should be a collaborative effort between the generator and the RMW transporter. Adhering to sound medical waste practices can save you the discomfort of a difficult inspection, the embarrassment of unfavorable publicity, and the possiblity of costly fines. ■

Mr. LaCarrubba is the director of Medical Services Division, a division of Solid Waste Technologies, Inc., Somerset County. The paper was submitted and accepted in January 1991. Requests for reprints may be addressed to Mr. LaCarrubba, Solid Waste Technologies, 50 Mt. Bethel Road, Warren, NJ 07059.

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PURE SQUAMOUS CELL CARCINOMA OF THE BREAST

Bernard Peison, MD
Barry Benisch, MD
Harold Chung-Loy, MD

The authors report a case of a pure squamous cell carcinoma of the breast with osteoclast-like stromal giant cells. These rare tumors should be diagnosed only after complete sampling has excluded an adenocarcinoma with squamous metaplasia or origin in the overlying skin.

A 45-year-old woman was admitted to Rahway Hospital in December 1988, with a six-week history of a tender mass in the inner aspect of her left breast. The patient had benign biopsies at the same site in the left breast 16 and 20 years previously. Excisional breast biopsy revealed a rounded tumor mass measuring 4.5 x 4.0 x 3.0 cm. Sections of tumor revealed a partly cystic, gray indurated, cut surface with a necrotic hemorrhagic center. Histological examination of the tumor revealed diffusely infiltrating nests of keratinizing squamous cell carcinoma displaying marked anaplasia with numerous abnormal mitotic figures (Figure 1). There were large areas of necrosis and hemorrhage with malignant squamous epithelium lining the cystic portions of the tumor. In two selected areas, large aggregates of osteoclast-like giant cells were present (Figure 2). Some of the mammary ducts were filled with squamous cell carcinoma but no metaplastic changes were observed in the uninvolved adjacent ductal epithelium (Figure 3). The adjacent breast tissue was markedly fibrotic with evidence of previous bleeding. The mucin stain was negative and the antikeratin, pankeratin, and epithelial membrane antigen immunoperoxidase stains were positive. The osteoclast-like stromal giant cells stained negative with keratin, pankeratin, epithelial membrane antigen, and vimentin immunoperoxidase stains. Estrogen and progesterone receptor studies were negative.

A modified left radical mastectomy was performed, revealing a single, small focus of residual squamous cell carcinoma within a mammary duct. In addition, there were changes of fibrocystic disease and a small epidermoid cyst near the skin of the nipple. No tumor cells were identified in 17 axillary lymph nodes. The patient was treated postoperatively with Cytoxan®, Methotrexate®, and Fluorouracil® for nine cycles. The patient is doing well, with no evidence of metastatic disease.

DISCUSSION

Pure squamous cell carcinoma of the breast is a very rare disease. Eggers and Chesney identified 2 cases of pure squamous cell carcinoma in a total of 4,351 malignant breast neoplasms.[1] A similar incidence was reported by Toikkannen, who found 3 pure squamous cell carcinomas upon re-examination of 4,000 breast biopsies.[2] Furthermore, with the exception of rare, well-documented cases of pure squamous cell carcinomas,[1-6] the vast majority of the reported cases actually are adenocarcinomas with squamous metaplasia, a phenomenon with an estimated frequency of 3.6 percent.[7,8] Although the association of squamous differentiation is most common with ductal adenocarcinoma and anaplastic carcinoma, it also can occur with other tumors of the breast including medullary carcinoma and cystosarcoma phyllodes.[9] Cornog reported 24 cases of breast carcinoma in which squamous differentiation was a prominent feature.[9] Two carcinomas were apparently of pure squamous type. Eggers reported 8 cases of squamous cell carcinoma of the breast.[1] Two cases were pure squamous cell carcinomas and 6 cases displayed various combinations of malignant squamous elements and ductal adenocarcinoma. Fisher described 5 cases of squamous cell carcinoma of the breast;[7] 3 cases had a phyllode gross and microscopic appearance. However, in all, the stroma lacked sarcomatous features.

From the files of the Armed Forces Institute of Pathology, Wargotz and Norris identified 22 cases of pure squamous cell carcinoma of the breast. Only 2 of the 19 women with axillary dis-

section had metastases, but 1 woman had a positive supraclavicular lymph node in the presence of negative axillary lymph nodes. Sixteen neoplasms were predominantly cystic with an irregular lining composed of squamous carcinoma. Immunohistochemical study for S-100 protein identified an immunoreactive cell component in 5 of 7 neoplasms tested, suggesting myoepithelial proliferation, differentiation, or origin. Hasleton presented evidence that squamous cell carcinoma arises through metaplasia of ducts leading to carcinoma.[10] The reason for metaplasia is unknown, but could result from infection and/or inflammation. In a series of 1,760 breast cancers, Woodard found ultrastructural evidence of glandular differentiation in 5 cases regarded by light microscopy as purely squamous.[11] Cornog pointed out that the relatively large number of cystic tumors may account for early reports of pure squamous cell carcinoma arising in epidermoid cysts.[9] Macia reported a case of pure squamous cell carcinoma diagnosed by aspiration cytology.[4]

In our case, the squamous cell carcinoma originated within the glandular breast tissue and no connections to previous lesions nor the skin could be observed after examining more than 60 slides. Although the tumor was partially cystic, a true cyst wall was not identified, but central necrosis lined by squamous carcinoma was present. There are reported cases of spindle cell carcinoma of the breast that have been classified as squamous cell carcinoma; this pattern was not present in our case.

The diagnosis of pure squamous cell carcinoma must fulfill three conditions: no other neoplastic elements such as ductal or mesenchymal foci are present in the tumor; the tumor is independent from adjacent cutaneous structures; and no other primary epidermoid tumor exists in the patient. Our case complied with these three criteria. Approximately 24 cases of pure squamous cell carcinoma of the breast have been reported.[6]

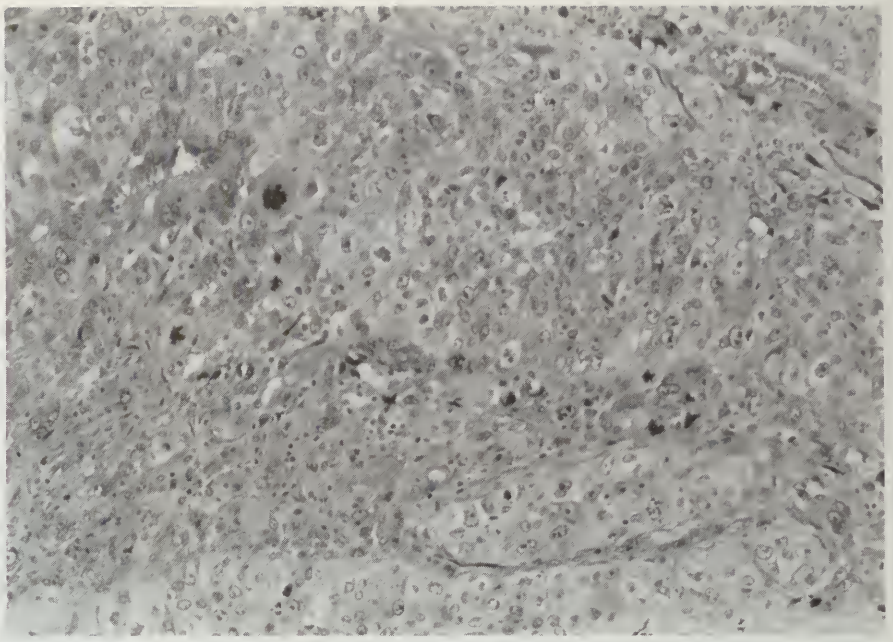


Figure 1. Squamous cell carcinoma with nuclear pleomorphism and bizarre mitotic figures (H&E x 100).

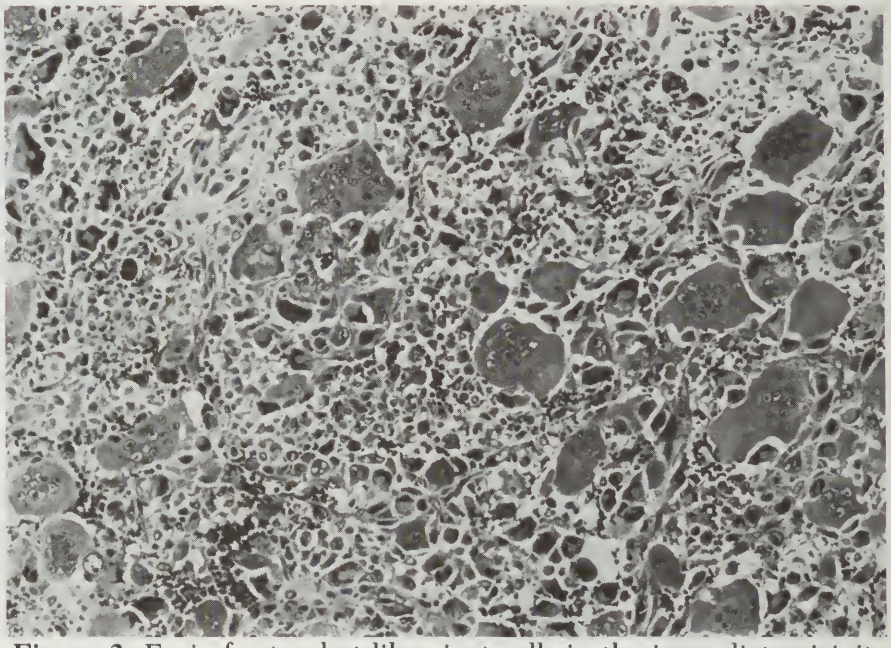


Figure 2. Foci of osteoclast-like giant cells in the immediate vicinity of cluster of tumor cells (H&E x 100).

Another distinctive feature identified in our case was the presence of osteoclast-like stromal giant cells. The presence of multinucleated osteoclast-like stromal giant cells within breast neoplasms has been reported sporadically. Agnantis and Rosen reported eight cases of mammary carcinoma with benign osteoclast-like giant cells.[13] Five of the tumors were infiltrating ductal carcinoma and three of the tumors were infiltrating lobular carcinoma. Three cases also had squamous or spindle cell metaplasia. Although three of their patients had nodal metastases, none of the positive nodes contained giant cells. Polarization of all histologic slides did not show birefringent crystals, hemosiderin or erythrocytes within the multinucleated giant cells. They postu-



Figure 3. Cystic portion of tumor with large mammary duct filled with squamous cell carcinoma (H&E x 20).

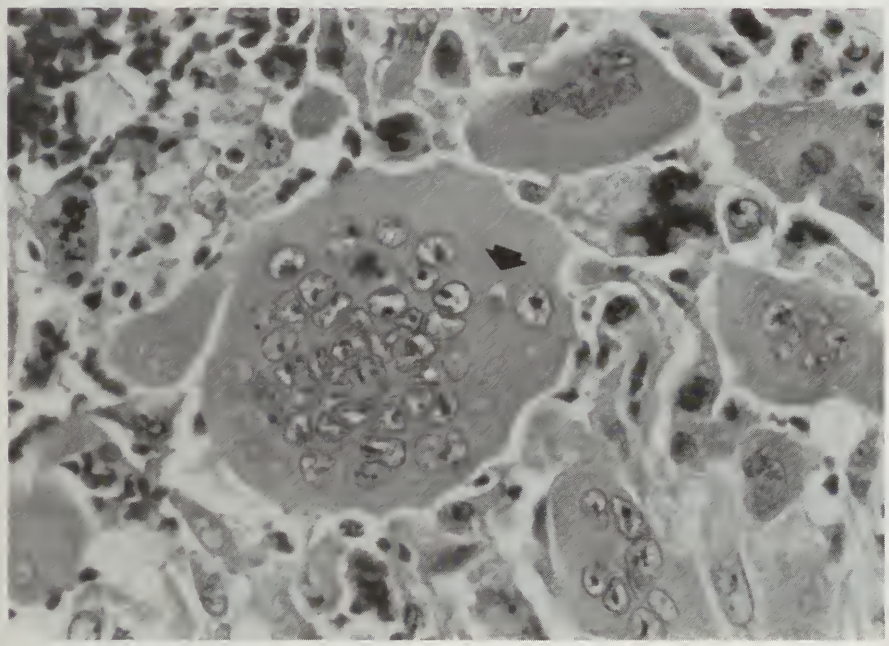


Figure 4. Multinucleated osteoclast-like giant cell with ingested hemosiderin granule (arrow) (H&E x 400).

lated that the giant cells are formed as a result of an unusual stromal reaction rather than by metaplasia from altered neoplastic cells. Holland reported six cases of mammary carcinoma with osteoclast-like giant cells and expressed the theory that these giant cells develop from mononuclear histiocytes in response to unidentified extracellular material produced by tumor cells.[14] He further indicated the benign giant cells comprise an integral part of the invasive tumor growth since the cells were present in all of the 26 lymph nodes of three patients. Nielsen and Kiaer reported three cases of invasive mammary ductal carcinoma with stromal osteoclast-like giant cells.[15] In the stroma, all specimens showed numerous osteoclast-like giant cells, vascular proliferation, and accumulation of hemosiderin pigment. Histochemical and electron microscopical investigation indicated that the giant cells originated from mononuclear stromal cells with only a suggestion of histiocytic properties. Tavassoli and Norris reported seven cases of ductal carcinoma of the breast with osteoclast-like giant cells.[16] Recurrences and lymph node metastases also contained osteoclast-like giant cells. The giant cells were histologically benign and histochemical and ultrastructural studies revealed them to be of reactive type and of stromal origin.

In our case, the osteoclast-like giant cells were localized to two single foci in a fibrovascular, hemorrhagic stroma containing granules of hemosiderin, and adjacent to nests and cords of invasive squamous cell carcinoma. The giant cells contained up to 40 centrally placed nuclei with a rounded convoluted outline and conspicuous bright red nucleoli but without nuclear pleomorphism or mitosis. The cytoplasm was abundant and contained granules of hemosiderin, intact erythrocytes, and/or vacuoles (Figure 4). The mechanism by which the giant cells are formed is not completely settled although it generally is accepted that the cells originate by fusion of histiocytes and apparently play a defensive role against the invading tumor cells. Repeated mitotic division of the latter or amitotic division of the nucleus without cytoplasmic division and endoreduplication followed by endomitosis also have been proposed.[17] ■

References available upon request.

Drs. Peison and Benisch are affiliated with the Department of Pathology and Dr. Chung-Loy is affiliated with the Department of Surgery, Rahway Hospital. The paper was submitted in November 1990 and accepted in December 1990. Requests for reprints may be addressed to Dr. Peison, Rahway Hospital, 865 Stone Street, Rahway, NJ 07065.



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STUDENT CIGARETTE SMOKING HABITS

Paul H. Steel, MD

Identical surveys in 1965 and 1989 show cigarette smoking patterns for Atlantic County, New Jersey, students, grades 5 through 12, have decreased; yet, the number of female smokers has increased. Drug and alcohol experimentation are common for these students.

The Atlantic County Medical Society sponsored a survey in 1965 to determine cigarette smoking patterns of Atlantic County public and private school students.[1] In 1989, a facsimile of the original survey, with minor editorial changes, was prepared and an identical resurvey was conducted.

The purpose of this project was to compare the smoking habits for the two periods, 1965 and 1989. The full investigation was to determine the extent of cigarette smoking in school children, to determine possible causes, and to establish local antismoking educational programs.

METHODS AND MATERIALS

The survey consisted of a one-word or true/false questionnaire covering 22 items. It was distributed throughout the public and private Atlantic County school system, grades 5 through 12 inclusive (Figure 1). Each teacher read a prepared explanatory message; after the test, unsigned questionnaires were collected anonymously. The results were tabulated by a select group of senior students in the Atlantic City High School computer class.

RESULTS

In 1965, there were 17,389 children in grades 5 through 12; of these, 16,486 students (94 percent) participated in the project. In 1989, there were 15,489 children in grades 5 through 12; of these, 13,839 students (92 percent) participated.

The survey pool numbers were adjusted to allow for absenteeism (5 percent) and for noncompliance. Egg Harbor Township, representing 2,600 available students, did not participate in 1989. The demographic makeup of these students is comparable to other county districts and, in view of the large number of total participants, it is believed that this had no epidemiological significance.

The 1965 survey involved 8,411 males and 8,075 females; 1,955 (23.2 percent) males and 1,485 (18.4 percent) females were present smokers.

The 1989 survey involved 6,739 males and 7,100 females; 603 males (8.9 percent) and 792 females (11.1 percent) were present smokers.

In 1965, 20.8 percent of the students smoked cigarettes compared to 10 percent of the students in 1989.

In 1965, 3,502 students (21 percent) recorded either being past or present smokers; of these, only 0.44 percent abandoned the habit.

In 1989, 6,265 students (45 percent) recorded either being past or present smokers; of these, 35.27 percent quit smoking.

The 1965 survey revealed the majority entry grade level for smoking was 7th grade. In 1989, this level was found to be at the 6th grade level (Figure 2).

The number of cigarettes smoked daily confirmed a generally light smoking load (Figure 3): 2,685 (78 percent) smokers in 1965 and 972 (70 percent) smokers in 1989 smoked less than one-half pack per day.

Answers to questions related to factors influencing cigarette smoking varied little between the two surveys. Peer pressure and parental smoking habits as a model frequently were mentioned. The subtle influence of the latter is demonstrated by the fact that, if the parent smokes, the likelihood of the child smoking is 63 percent.

Three new items were added to the 1989 survey; no attempts were made to stratify these raw totals, other than for sex (Table).

From the total 16,486 children surveyed in 1965, 2,296 children stated they did not smoke due to cost (14 percent), and 4,713 (29 percent) did not smoke because of health reasons. From the total of 13,839 children surveyed in 1989, 195 children stated they did

not smoke due to cost (1.4 percent), and 3,754 children (27 percent) did not smoke because of health reasons.

DISCUSSION

The overall diminution in the smoking habits of students grades 5 through 12 in Atlantic County, from 20.8 percent to 10.0 percent that parallels and perhaps exceeds the national trend, is most heartening. It appears to reflect positively on the educational endeavors of school authorities, health care providers, parents, the Surgeon General,[2,3] and organizations such as the American Heart Association, the American Lung Association, and the American Cancer Society.

Only the years 1965 and 1989 were cited in our survey. However, the fall in the percentage of smokers in Atlantic County students from 20.8 percent to 10.0 percent does appear to exceed the decline found nationally of 29 percent in 1976 to 19 percent in 1987.

A related national statistic dealing with a declining smoking experience in older age brackets is referred to in the 1989 Department on Health and Human Services publications;[2] the prevalence of smoking in adults fell from 40 percent in 1964 to 29 percent in 1989.

A recent study from Germany illustrated the efficacy of education in this matter. Gohlke reported a prospective controlled study in which 752 children were asked about their smoking experience; after this initial survey, the children were provided eight education lessons in an attempt to reinforce nonsmoking. In six control schools, the anti-smoking education was not provided.[5] After 2.3 years, 579 students answered a similar questionnaire. In the control schools, 12.4 percent of the students had begun smoking, compared to 7.4 percent of the students in the intervention schools. Daily smoking had been taken up by 8.4 percent of those who had not received the

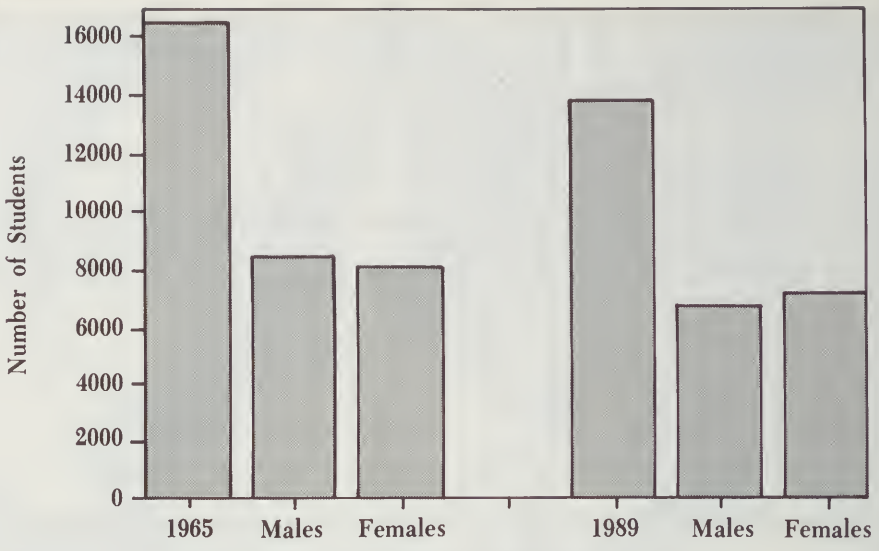


Figure 1. Students taking survey.

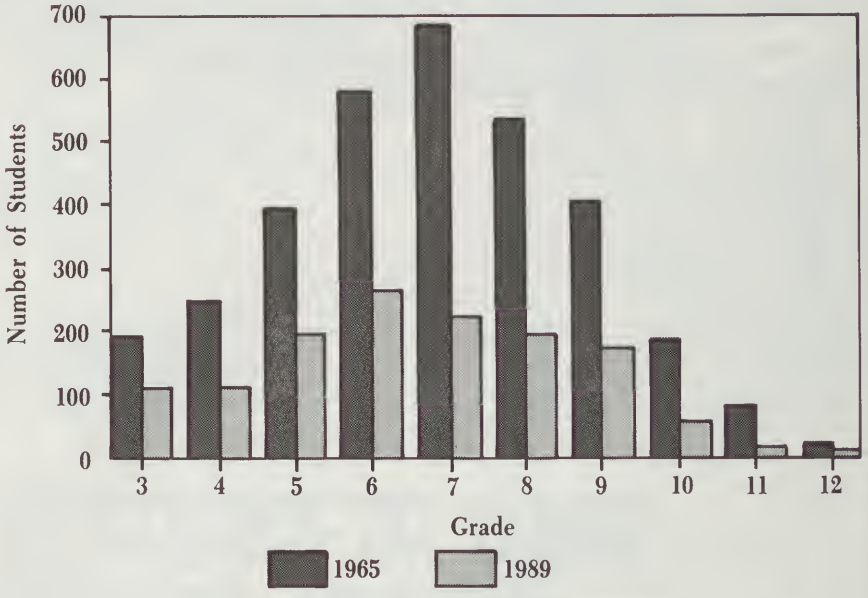


Figure 2. Grade smoking started.

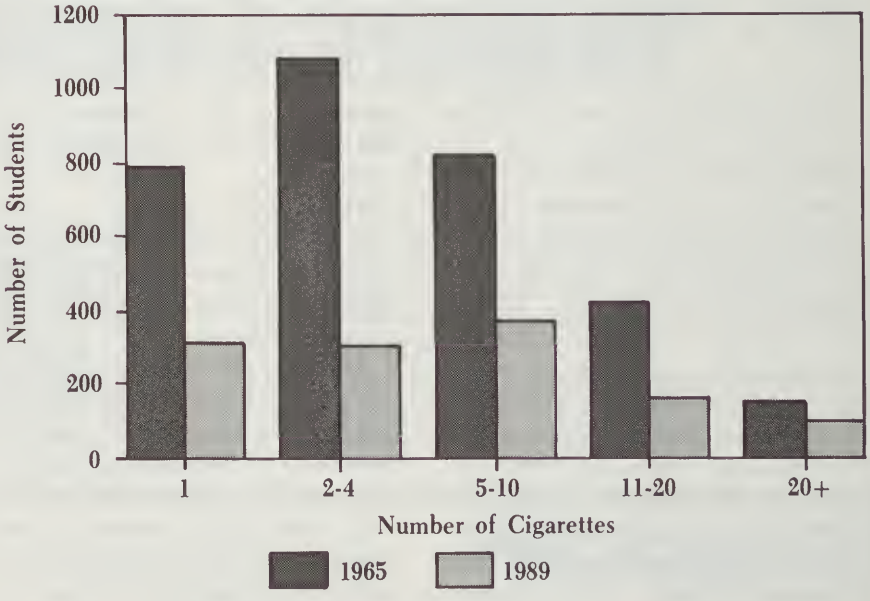


Figure 3. Cigarettes smoked daily.

Table. **New items in 1989 questionnaire.***

1. Total number who have smoked marijuana:

	Males 1,304	Females 1,365	
Frequency:	One time	Infrequently	Regularly
	1,177	877	424

2. Total number who have experimented with drugs:

Males 971 Females 864

3. Total number who have experimented with alcohol, including beer:

	Males 4,275	Females 4,432	
Frequency:	One time	Infrequently	Regularly
	2,260	4,649	1,023

*Numbers do not necessarily match, as all students did not reply to all questions.

intervention lessons but by only 4 percent of those who had. The authors concluded that eight hours of educational instruction aimed at reinforcing nonsmoking generated a lasting influence on the smoking behavior of adolescents.

For a time following our 1965 publication, which received national attention and provided important data useful at a time when anti-smoking sentiment was just beginning, the Medical Society of Atlantic County provided anti-smoking programs for the county school system. A physician speakers bureau was established. The general format of these programs consisted of a talk, movie, and question-and-answer session; also, informative literature was distributed.

Our survey revealed that smoking experimenters more than doubled from 1965 to 1989 (21.24 percent to 45.27 percent, respectively). The good news is that in 1965, only 0.44 percent of the smokers had quit whereas in 1989, 35.27 had abandoned the habit. These facts would seem to indicate that even though youthful inquisitiveness had increased, a natural trait that should be encouraged, there now exists an informed inquisitiveness. One could safely assume there has been a positive response to the various anti-smoking programs. And, both surveys confirm that the target year date should be lowered and anti-smoking education should commence at least in the 5th grade and preferably lower.

The increase in female smoking is clearly demonstrated. Specific efforts to discourage this trend are important. Although motherhood is certainly remote for most of these students, the adverse consequences of smoking during childbearing years is yet another compelling reason to discourage female smoking. It is axiomatic that nonsmoking females have no concerns in this regard.

The response to the three questions added in 1989 is disturbing: 63 percent of students polled admitted to experimenting with alcohol, whereas 45 percent experimented with nicotine. A national survey stated one in two high school students tried alcohol.[4] Our survey is more general and probably indicates significant activity below high school level.

The universal philosophy of immortality that youngsters hold out for themselves makes the elimination of smoking a difficult challenge. The health consequences of nicotine consumption generally, after all, are not appreciated for many years.

This is not the case with drugs and alcohol. Results of their usage can be immediate and tragic. The devastating societal consequences of drug usage are obvious. The damages of alcohol abuse, particularly for teenage drivers under the influence, can be monumental.

The alarming findings, although not quantitative, show 1,835 students (13 percent) experimented with drugs and 8,707 students (63 percent) have experimented with alcohol. This compares with a total of 6,265 students (45 percent) who have experimented with smoking.

Obviously, greater efforts are needed to discourage this surprising level of involvement with drugs and alcohol. Continuing enhanced anti-drug, alcohol, and smoking educational programs are imperative. ■

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This paper was submitted in June 1990 and accepted in December 1990.

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CT AND MRI OF HEPATIC HEMANGIOMA

James H. Jacoby, MD
Mark T. DiMarcangelo, DO

The authors describe computed tomography (CT) and magnetic resonance imaging (MRI) characteristics of giant hepatic hemangioma in a 68-year-old woman; she was referred because of questionable hepatic enlargement.

A 68-year-old white female had a significant past history for treatment for uterine cancer 20 years earlier by preoperative irradiation followed by radical hysterectomy. She remains essentially well and asymptomatic but was referred for computerized tomography (CT) evaluation of her abdomen, because of questionable hepatic enlargement (Figure 1). Liver chemistries were normal.

DISCUSSION

The discovery of a large focal mass in the liver of an asymptomatic patient certainly can be disconcerting. Such circumstances, however, are common with the widespread clinical use of sonography and CT.

Typically, cysts are readily distinguishable from solid masses by their characteristic sharply defined borders, by their anechoic nature on ultrasound, and by their uniformly water-dense appearance on CT. Solid tumors may present more of a diagnostic dilemma and may require additional studies to differentiate benign from malignant lesions.

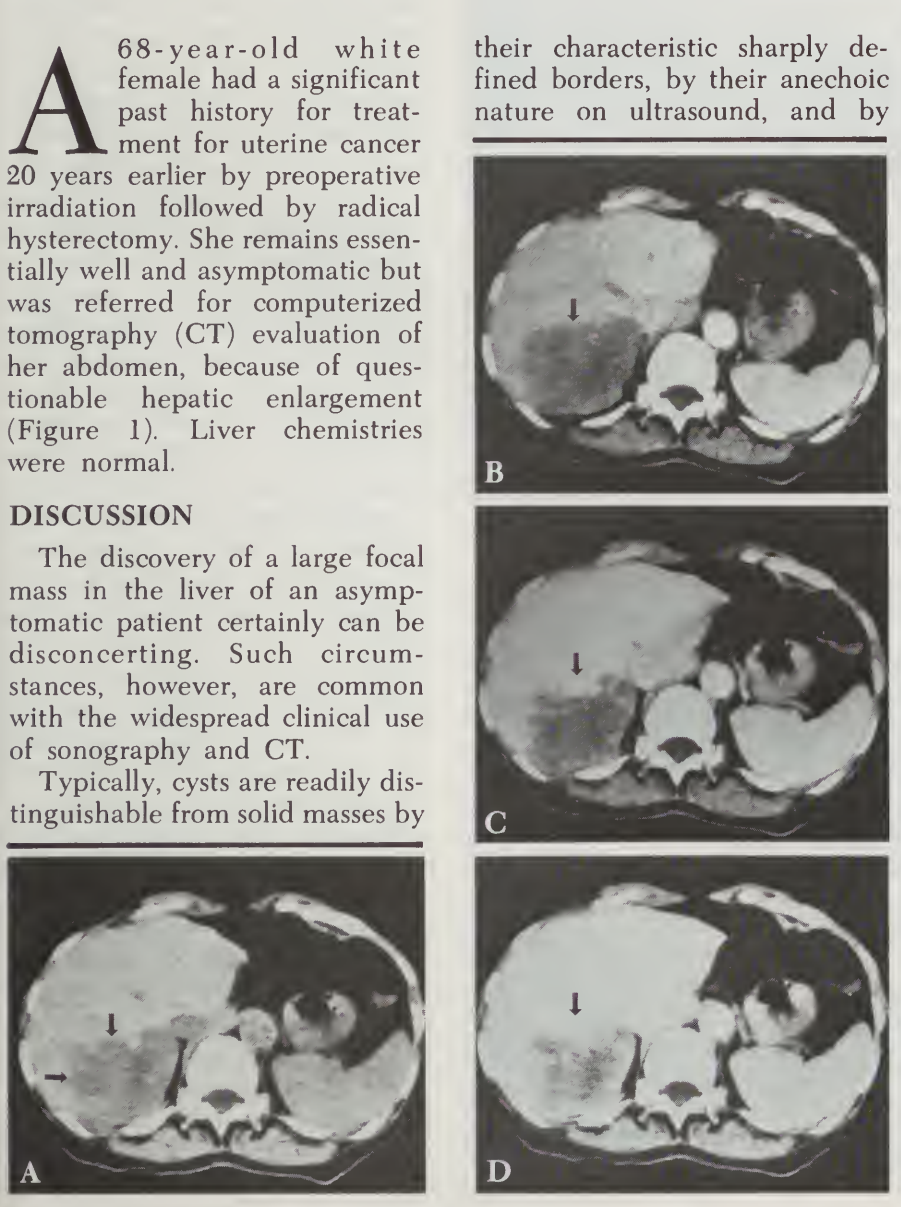
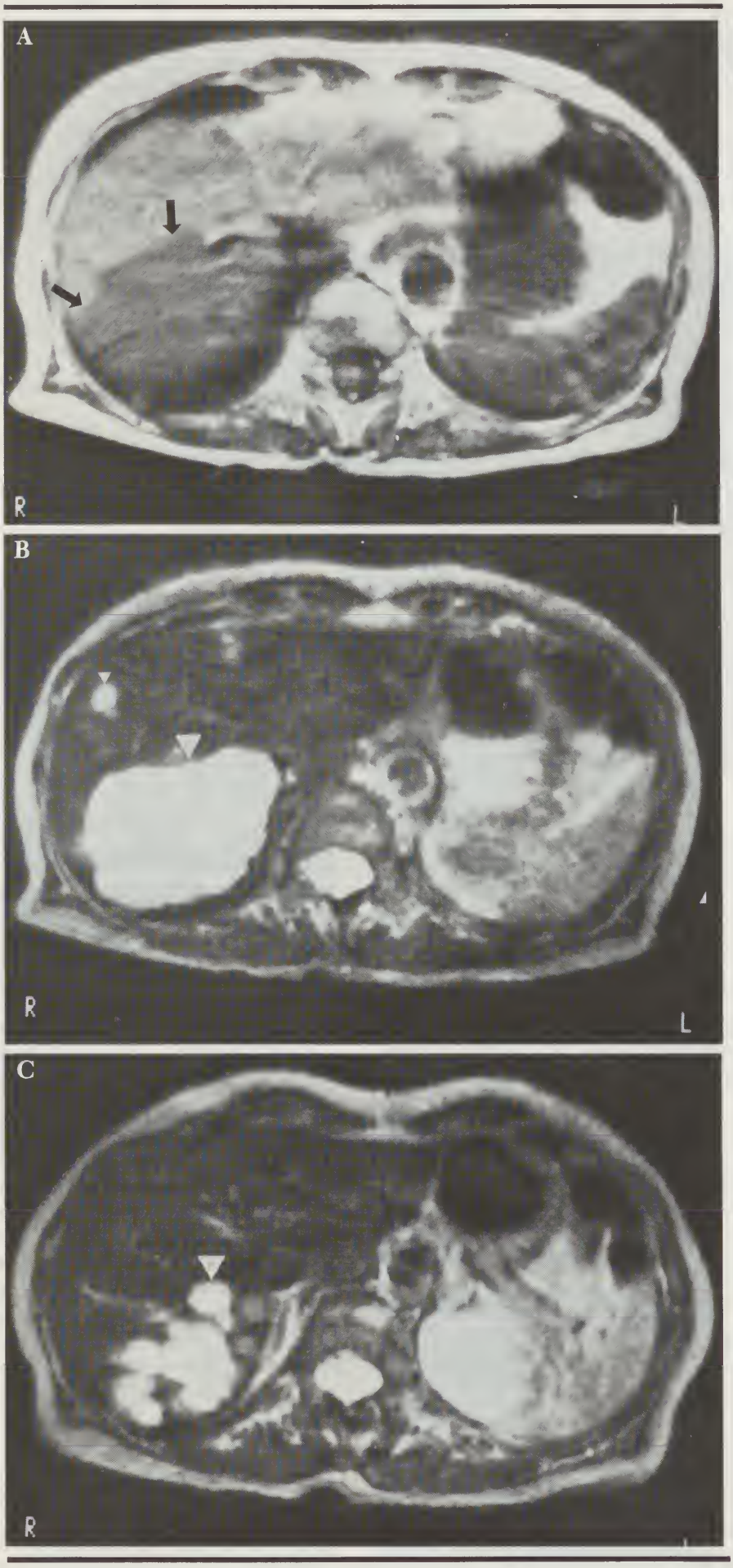


Figure 1. Axial CT sections through the liver reveal nodular area of altered attenuation in the right lobe: (A) precontrast, mass in diminished attenuation (arrows); (B) immediately after bolus IV contrast, attenuation (arrows); (C) 1 minute postcontrast, filling in density from periphery (arrows); (D) 3 minutes postcontrast, further filling of density (arrows); (E) 5 minutes postcontrast, almost complete filling in of density (arrows); (F) 13 minutes postcontrast, small cleft of diminished density remaining (arrows).



Hemangiomas are the most common solid benign tumor of the liver, having an incidence of 5 to 15 percent, and may be solitary or multiple. Large, giant cavernous hemangiomas are less common, however, and actually are more likely to produce symptoms, although clinical manifestations are rare. Hemangiomas larger than 4 to 6 cm generally are considered giant cavernous hemangiomas.

Computerized tomography findings in giant cavernous hemangiomas have been reported as being characteristic although this is subject to some controversy. Prior to intravenous contrast enhancement, the tumor borders are sharp and the tumor density is similar to that of the inferior vena cava or portal veins. Cleft-like zones frequently are observed. Itai analyzed the enhancement characteristics in 52 hemangiomas[1] and described enhancement patterns rarely seen in other liver tumors: (1) dense accumulation of contrast material that spreads in all directions within the mass on sequential scans; (2) diffuse density higher than normal liver at two minutes; (3) progressive reduction of the visible lesion area to disappearance; and (4) density greater than normal liver (other than capsule or septa) on scans at three minutes or more after administration of contrast. Itai and colleagues regarded the presence of

Figure 2A. Axial T1 weighted MRI through liver reveals focal large area of diminished signal intensity (arrow) corresponding to abnormality noted on CT.

Figure 2B. Axial T2 weighted MRI through similar area demonstrates very bright signal intensity (large arrowhead) with a smaller adjacent area of bright signal intensity (small arrowhead).

Figure 2C. Axial T2 weighted MRI through a more inferior level of the liver demonstrates a very nodular, but homogeneously bright signal intensity, component of this mass (arrowhead).

any of the above criteria as definite for the diagnosis of cavernous hemangioma; others also have observed the tendency for early peripheral enhancement and centripetal filling.

Our case displays the presence of an 8.2 cm, well-defined, hypodense tumor with attenuation similar to that of the inferior vena cava (Figure 1A). Following bolus intravenous contrast enhancement, puddles of dense accumulation of contrast are seen in a multicentric pattern but primarily in the tumor periphery (Figure 1C), thus fulfilling Itai's first criteria. Overall density of the mass, however, does not become greater than that of the normal liver. In addition, although the bulk of the mass becomes isodense on late images, there still remains a cleft of hypodensity even at 13 minutes (Figure 1F), that is thought to represent a central area of scarring. The liver otherwise was normal and not enlarged.

Freeny points out, however, that the contrast enhancement patterns of hemangiomas and metastases overlap, although, in the appropriate clinical setting, most liver tumors found in oncology patients will be metastases and most found in asymptomatic patients will be hemangiomas.[2] There actually is only an 86 percent chance that a lesion showing the "typical" hemangioma CT pattern, in fact, is a hemangioma if it is discovered in an oncology patient.[3] Because of this uncertainty, magnetic resonance (MR) imaging (Figure 2) was performed in this patient.

Since cavernous hemangiomas are essentially lakes of slowly flowing blood, MR evaluation with pulse sequences favoring heavily T2 weighting demonstrate very bright signal intensity.[4] The degree of this bright signal intensity almost always is significantly greater than metastatic lesions.

Nevertheless, overlap of this appearance may occur with hypervascular tumors such as hypervascular endocrine tumors, sarcomas, uterine carcinoma, pelvic rhabdomyosarcoma, gastric lieomyoblastoma, and lung carcinoma. However, the accuracy of diagnosing cavernous hemangioma by MR is 90 percent if the following criteria are fulfilled: smooth contours that are typically lobulated; homogeneous on all pulse sequences; intense high signal on T2 weighted pulse sequences; and continued increase of signal relative to liver with longer TEs.[5]

Conversely, metastases frequently display heterogeneity, rings, or solid satellite tumors and are of lesser signal intensity on T2 images than hemangiomas.

SUMMARY

Our patient exhibited typical characteristics of giant cavernous hemangioma by CT and MR, and was asymptomatic. We have concluded, therefore, that this did not represent a malignant lesion. In general, however, one must exhibit a reasonable degree of caution in applying this diagnosis, adhere strictly to the criteria described, and recognize the clinical setting of the patient.

Diagnosis: Giant cavernous hemangioma of the liver. ■

Dr. Jacoby is acting chief and Dr. DiMarcangelo is an associate, Department of Diagnostic Radiology and Nuclear Medicine, Cooper Hospital/University Medical Center.
This paper was submitted in December 1990, and accepted in January 1991.
Address requests to Dr. Jacoby, Cooper Hospital/University Medical Center, One Cooper Plaza, Camden, NJ 08103.

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PROFOUND PRIMARY HYPOTHYROIDISM

Michael Goldman, MD
James Marley, MD
Abe Steinberger, MD
Sundara Ganti, MD

Profound primary hypothyroidism is described, presenting as a pituitary tumor in a 46-year-old male with hyperprolactinemia and hypogonadotropic hypogonadism. Replacement therapy with thyroxine reversed all of the patient's abnormalities.

Primary hypothyroidism can simulate prolactinomas by causing pituitary enlargement and elevated prolactin levels.[1] It also has been shown to alter other pituitary hormones.[2,3] This case report documents pituitary enlargement, hyperprolactinemia, and uniquely hypopituitarism, reversed solely by thyroid hormone replacement.

CASE REPORT

A 46-year-old white male was referred because of a pituitary tumor. Four months earlier, he was evaluated by a neuro-ophthalmologist for horizontal diplopia. Examination at that time revealed weakness of upward gaze bilaterally. Visual fields were normal. Magnetic resonance imaging (MRI) of the pituitary revealed a large macroadenoma with suprasellar extension with "indentation of the optic chiasma and obliteration of the pituitary stalk" (Figure 1). A diagnosis of the C. Miller Fisher variant (an ophthalmoparesis) of the Guillain-Barré syndrome was made, along with that of a pituitary tumor.[4] Symptomatic therapy for the diplopia with the use of an eye patch was advised.

Endocrine studies at that time revealed prolactin was 40 ng/ml (normal: 0-15 ng/ml); testosterone was 1.6 ng/ml (normal: 3.6-9.9 ng/ml); FSH was 4.4 mIU/ml (normal: 1-14 mIU/ml); LH was 0.9 mIU/ml (normal: 1.5-9.2 mIU/ml); thyroxine (T4) was 1.3 μg/dl (normal: 4.5-12.5 μg/dl); and TSH level was 803 μIU/ml (normal: 0.3-5.0 μIU/ml).

When seen in endocrine consultation, the patient noted loss of energy, poor activity tolerance, dry skin, poor sexual functioning, and weight gain of 40 pounds. There was no significant past medical or family history.

Physical examination revealed a slow-moving, obese male weighing 232 pounds. No diplopia was observed. The thyroid was small and symmetrical without nodularity. The skin was soft and dry. Reflexes showed a marked delayed reaction. Data revealed TSH of 360

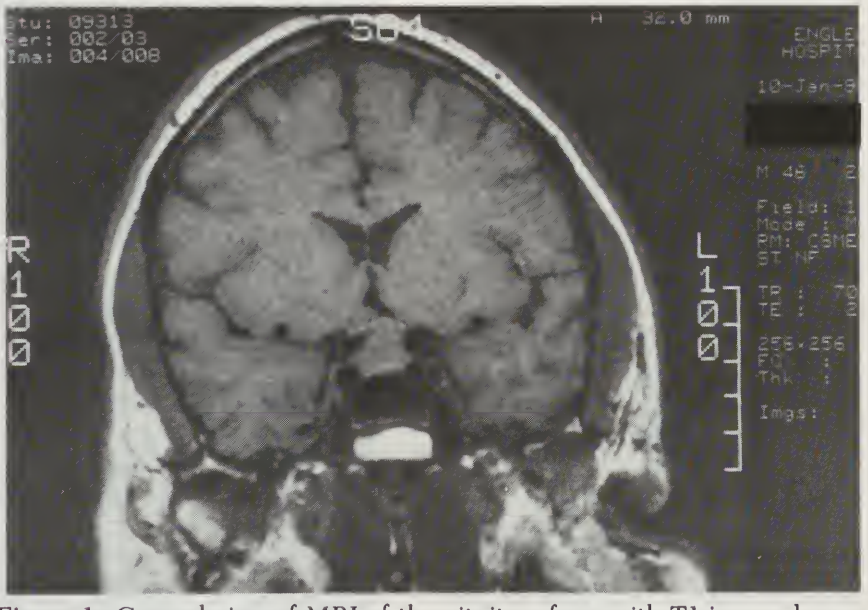


Figure 1. Coronal view of MRI of the pituitary fossa with T1 image demonstrates an intrasellar mass with suprasellar extension displacing the optic chiasm superiorly as well as obliterating the suprasellar cisterns and slightly indenting the third ventricle. There is no hydrocephalus of frontal horns. There is slight lateral displacement of the cavernous and supraclinoid carotid artery segment.

μIU/ml (normal: 0.5-3.7 μIU/ml), baseline cortisol of 10.2 mcg/dl, and post-ACTH cortisol of 19.9. Antimicrosomal antibodies were significantly elevated at 1:6,400 (normal: 1:400). Thyroxine replacement was begun and titrated to 0.15 mg per day. After three months of therapy, the patient noticed increased muscle strength, and a loss of 12 pounds. Both TSH and prolactin levels normalized. A repeat MRI showed a significant reduction in the size of the pituitary tumor. A slight bulging of the tumor out of the pituitary fossa was reported and the pituitary stalk now was fully seen. After six months of therapy, the patient noticed increased hair growth and a deepening voice. Testosterone level was normal at 498 ng/ml (normal: 270-1,070 ng/ml). Three months later, MRI of the pituitary was normal (Figure 2).

DISCUSSION

Hypothyroidism may cause multiple effects on the pituitary gland including enlargement (hyperplasia or adenoma),[5] hyperfunction (prolactin),[1] or hypofunction (partial hypopituitarism).[3]

The concurrent presentation of pituitary enlargement with hyperprolactinemia seen in primary hypothyroidism mistakenly can be thought to be a prolactinoma and should be distinguished from it by an increased TSH level. Even mild hypothyroidism with normal thyroxine levels may cause marked hyperprolactinemia.[6] Hyperplasia or adenomatous transformation of pituitary thyrotropic cells in response to primary thyroid deficiency is thought to cause pituitary enlargement.[5] Abnormalities in dopamine-prolactin interactions have been found to be present in hypothyroid patients and may contribute to the elevated prolactin levels.[2] Reversibility of these abnormalities with thyroxine replacement has been reported and was documented in our patient.

Other pituitary hormonal alterations may occur in hypothyroidism. Growth hormone elevations and paradoxical release patterns have been demonstrated.[2] Also, panhypopituitarism including adrenal, gonadal, and prolactin deficiencies were reported in two cases.[3] In neither patient was reversal of these hormonal abnormalities described. In the patient presented, normalization of testosterone was found to occur six months after instituting thyroid replacement therapy. Presumably, shrinkage of the pituitary mass decompressed the pituicytes to allow for the return of normal functioning.

Reversible hypopituitarism previously has been reported in patients with pituitary disease both treated (resection of nonfunctioning pituitary tumors),[7] and untreated (spontaneously in a pituitary mass postpartum).[8] It also has been shown to occur in other endocrine disorders (following resection of an adrenal tumor in Cushing's syndrome).[9] Hypothyroidism may be added to this list.

The ophthalmoparesis resolved spontaneously within two months of its onset. ■

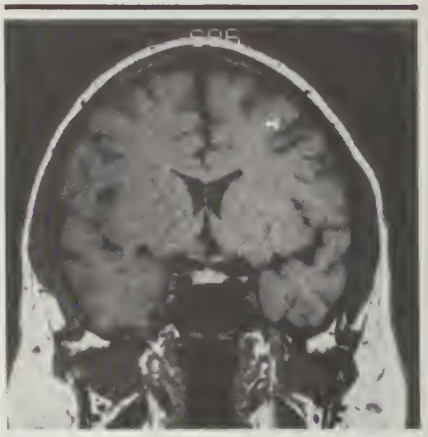


Figure 2. MRI examination of pituitary fossa after the therapy coronal views with T1 images reveals a marked decrease in the size of the pituitary tumor with almost normal location of the optic chiasm compared to the previous examination (Figure 1).

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Publication	2 years	Clement H. Kreider, Jr, MD, Monmouth

*Unexpired term of Frank Y. Watson, MD, who resigned January 11, 1991.
**Vacancy created by resignation of Frederick W. Durham, MD, on December 31, 1990.

†Unexpired term of Donald J. Cinotti, MD, who resigned January 29, 1991.

1991 MSNJ ANNUAL MEETING

The Board of Trustees of the Medical Society of New Jersey approved the Committee on Annual Meeting's recommendation that the 1991 Annual Meeting be held at the Trump Taj Mahal Casino/Resort in Atlantic City, on Sunday, April 28, through Wednesday, May 1, 1991. (Housing Application is on page 293.) The daily schedule follows:

Saturday, April 27, 1991

3:30 p.m. Board of Trustees' Meeting

Sunday, April 28, 1991

8:00 a.m. Registration Opens
8:00 a.m. Message Center Opens
10:00 a.m. Educational Programs*
11:30 a.m. Exhibits Open
1:30 p.m. House of Delegates
3:30 p.m. Reference Committee Meetings

Monday, April 29, 1991

8:00 a.m. Registration Opens
8:00 a.m. Message Center Opens
8:30 a.m. Exhibits Open
9:00 a.m. House of Delegates (Election)
12:00 noon Golden Merit Award Ceremony and Reception
2:30 p.m. Reference Committee Meetings
5:00 p.m. JEMPAC Political Forum
5:45 p.m. JEMPAC Wine and Cheese Reception
6:30 p.m. Union County Medical Society Reception

Tuesday, April 30, 1991

8:00 a.m. Registration Opens
8:00 a.m. Message Center Opens
8:30 a.m. Exhibits Open
9:00 a.m. House of Delegates
1:30 p.m. House of Delegates
7:00 p.m. Inaugural Reception and Dinner
honoring Doctor and Mrs. Joseph A. Riggs

Wednesday, May 1, 1991

8:00 a.m. Registration Opens
8:00 a.m. Message Center Opens
8:30 a.m. Educational Programs**
1:00 p.m. Board of Trustees' Meeting

*see Pages 290, 291
**see Page 292

Reporting of Physician Privileges and Malpractice Insurance Information to State and Federal Agencies

The National Practitioner Data Bank and the Professional Medical Conduct Reform Act of 1989

10:00 A.M., Sunday, April 28, 1991
Topaz Room, First Floor

The Health Care Quality Improvement Act of 1986 and the Professional Medical Conduct Reform Act of 1989 have mandated the reporting of malpractice settlements and verdicts, along with certain adverse privilege actions to the National Practitioner Data Bank and the State Board of Medical Examiners. Physicians have been understandably concerned about the impact of reporting such information to licensing and credentialling authorities. However, many have not had access to clear information on these reporting systems.

OBJECTIVES

Presentations by speakers from both reporting and receiving agencies will enable participants to:

- Understand the goals and objectives of these systems.
- Identify what events are reportable, and what data are reportable.
- Recognize the impact of these report mechanisms.
- Take actions necessary to protect their interests.

9:30 A.M. **Coffee and Registration**

10:00 **Welcome and Introduction**
James E. George, MD, JD, Moderator
Director, Department of Professional Liability Control
Medical Society of New Jersey

10:15 **The New Jersey View—Reporting and the State Board of Medical Examiners**
Michael B. Grossman, DO
President, New Jersey State Board of Medical Examiners

11:00 **The Federal Perspective—The National Practitioner Data Bank**
Adam P. Wilczek
Vice-President, Risk Prevention
Medical Inter-Insurance Exchange of New Jersey

11:30 **Panel Discussion**

12:00 **Adjournment**

Environmental Issues in New Jersey Medicine

Cosponsored by the Academy of Medicine of New Jersey and the Medical Society of New Jersey's Committee on Environmental Health

SUNDAY, APRIL 28, 1991
Tiara A, First Floor

Over the past two years, changes have occurred with the New Jersey State Department of Environmental Protection and the New Jersey State Department of Health dealing with two problem areas: the disposal of medical waste and questions arising from the extensive involvement with occupational medicine. Physicians now are responsible for keeping records on their disposition of medical waste and are accountable to the Department of Environmental Protection in this area. Violators face heavy fines and possible criminal penalties if waste is not treated properly. Right-to-know laws also are questioning a possible causal relationship between employee illness and the work environment.

OBJECTIVES

The practitioner will:

- know when to take an occupational/environmental history
- be aware of the practical components of an occupational/environmental history
- know the four World Health Organization categories of occupational disease
- be familiar with specific techniques for linking exposure to disease based on historical, laboratory, radiographic, pulmonary function, and other criteria
- be aware of resources for expert consultation in evaluation or complex occupational/environmental problems
- be aware of New Jersey's medical waste laws regarding solid waste management
- understand medical waste generator's specific responsibilities under today's regulations for management and disposal of regulated medical wastes

9:30 A.M.	**Registration**
10:00	**Welcome** Stanley R. Lane, MD, Chairman, MSNJ Committee on Environmental Health
10:05	**Practical Evaluation of Patient Concerns about Occupational and Environmental Problems** Howard M. Kipen, MD, MPH Assistant Professor, Department of Environmental and Community Medicine, UMDNJ-Robert Wood Johnson Medical School
11:05	**Questions**
11:25	**Break**
11:40	**Physicians Role in Complying with New Jersey's Medical Waste Regulations** Robert Confer Chief, Bureau of Special Waste Planning, Division of Solid Waste Management, New Jersey State Department of Environmental Protection Gary Sondermeyer Assistant Director, Policy and Planning, Division of Solid Waste Management, New Jersey State Department of Environmental Protection
12:40	**Questions**
12:55	**Summary and Adjournment** Stanley R. Lane, MD

THE ACADEMY OF MEDICINE OF NEW JERSEY designates this continuing medical education activity for 3 hours in Category I of the Physician's Recognition Award of the American Medical Association.

THE ACADEMY OF MEDICINE OF NEW JERSEY is accredited by the Accreditation Council for Continuing Medical Education to sponsor continuing medical education for physicians.

Changing Characteristics of HIV Infection

Cosponsored by the Academy of Medicine of New Jersey, the New Jersey State Department of Health, Division of AIDS Prevention and Control, and the Medical Society of New Jersey

WEDNESDAY, MAY 1, 1991
Tiara A, First Floor

Many of the widely held assumptions about prevention, diagnosis, and treatment of HIV infections need to be reassessed.

- The primary care physician now must consider the possibility of HIV infection in persons who are not members of the high-risk groups identified early in the epidemic. Women, children, and adolescents account for an increasing proportion of HIV infections, sometimes without having engaged in overtly high-risk behaviors.
- Clinical clues to suggest the diagnosis of HIV infection have become less reliable: *Pneumocystis carinii* pneumonia (PCP) and other illnesses that were characteristic of HIV infection early in the epidemic still occur, but a variety of other illnesses due to HIV infection occur with increasing frequency. Women and children have illnesses that often behave differently than illnesses in men; for example, and the natural history of HIV disease has been altered by the administration of zidovudine and PCP prophylaxis in early infection.
- Physicians and other health care workers (HCWs) also must consider the effects of HIV on their own practices since it is recognized that HIV may spread from patients to HCWs and from HCWs to their patients.

These changes require the clinician to reconsider strategies to identify, counsel, and test patients who are potentially infected and to modify the approaches used to prevent and treat HIV disease.

OBJECTIVES

Participants will be able to develop an effective case-management plan for HIV infection that can be implemented in their offices or clinics and will:

- recognize the role of antiviral and *Pneumocystis* prophylaxis in predisposing HIV-infected persons to new or atypical manifestations of HIV infection
- appreciate changing attitudes about counseling and testing for HIV infection and the underlying ethical and philosophical bases for those changes
- recognize unique patterns of infection in IV drug abusers, women, and children
- assess risks of transmission of HIV infection.

8:00 A.M.	**Registration & Coffee**
8:30	**Welcome** Dennis Quinlan, MD, Chairman, MSNJ AIDS Task Force
8:35	**New Concepts in Testing and Counseling for HIV Infection** John W. Sensakovic, MD, Ph.D. Physician Director, AMNJ AIDS PROGRAM Corporate Director of Medical Education, Cathedral Healthcare System Director of Nosocomial Disease Laboratory, St. Michael's Medical Center, Newark Associate Professor of Medicine and Infectious Disease, Seton Hall University School of Graduate Medical Education; Fellow, AMNJ
9:10	**Standardized Protocol for HIV Infections in Women and Children** James M. Oleske, MD, MPH Francois-Xavier Bagnoud Professor of Pediatrics Director, Allergy, Immunology & Infectious Diseases, UMDNJ-New Jersey Medical School; Medical Director, Children's Hospital AIDS Program at United Hospitals of NJ, Newark; Fellow, AMNJ
9:45	**Break**
10:00	**HIV Infection in the Health Care Setting** Richard E. Dixon, MD, Conference Chairman Medical Director, Helene Fuld Medical Center, Trenton Associate Professor of Medicine, Hahnemann University School of Medicine; Fellow, AMNJ
10:35	**Panel Discussion**
11:30	**Adjournment**

PREREGISTRATION REQUIRED

- THE ACADEMY OF MEDICINE OF NEW JERSEY designates this continuing medical education activity for 3 hours in Category I of the Physician's Recognition Award of the American Medical Association
- THE ACADEMY OF MEDICINE OF NEW JERSEY is accredited by the Accreditation Council for Continuing Medical Education to sponsor continuing medical education for physicians.

This program will be repeated on May 7, 1991 (Sheraton Newark Airport, Elizabeth, NJ) and May 21, 1991 (Sheraton Poste Inn, Cherry Hill, NJ). Call Margo Churchwell, AMNJ, 609/896-0486 for registration. Gerald H. Friedland, MD, Co-Director/AIDS Center, Montefiore Medical Center, will be the keynote speaker at the May 7 and May 21 events.

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DOCTORS' NOTEBOOK

TRUSTEES' MINUTES

A regular meeting of the Board of Trustees was held on February 1, 1991, at the executive offices in Lawrenceville. Detailed minutes are on file with the secretary of your county society. A summary of significant Board actions follows:

President's Report . . . Attended a meeting with the commissioner of health; noted that Drs. John A. Harman, David J. Sand, and Aaron A. Sporn received professional service awards in recognition of their outstanding services.

Exec. Director's Report . . .

1. Membership . . . Provided membership report as of January 31, 1991.

2. AMA Membership Recruitment . . . Agreed to refer the list of AMA nonmembers to the Ad Hoc Committee on Membership Recruitment for consideration, and to send the list to county medical societies.

3. Medical Waste . . . Approved a recommendation to direct mail notices to the membership as well as physicians insured by the Medical Inter-Insurance Exchange of New Jersey to give them an opportunity to register under the medical waste management program and to pay the current fee during the moratorium period.

4. Legislation . . . Noted concern that bill A-4367 (Mandatory Medicare Assignment) will be incorporated in Governor Florio's overall costs reform package; and submitted comments to Senator Codey on bill S-3251 (Implements Recommendations of Governor's Commission on Health Care Costs).

5. Medicare . . . Noted the following: funding shortfall confronting the Medicare program is under control, and claims processing timeliness standards should be met; new MAACs (limiting charges) have been released; summary of highlights of President Bush's budget proposal for the Department of Health and Human Services for fiscal year 1992; report on the Medicare Physician Advisory Council with Pennsylvania Blue Shield by Dr. Ian D. Samson; and MAAC exceeder letters for the current quarter were sent to 600 physicians, compared to 2,200 to 2,400 letters sent to physicians in August 1990.

6. Litigation . . . Noted the following: adverse ruling on the $100 annual licensing fee was rendered in the no-fault case, and is being appealed; ban on balance billing and the fee schedule issues are pending in the Tax Court; and an adverse opinion in the medical malpractice surcharge case was rendered and Judge Herbert Stern is proceeding to petition for certification to the Supreme Court.

7. Business Practice Rule . . . Comments on the business practice rule will be submitted to the State Board of Medical Examiners; and Dr. Michael Grossman, president, SBME, welcomes recommendations on the proposed rules.

Specialty Reports . . . Received reports from the University of Medicine and Dentistry; the New Jersey Hospital Association; and the MSNJ Auxiliary.

State Board of Medical Examiners . . . Noted the following items from Dr. Grossman's report: inaugural meeting of the practitioner review panel; colleague reporting; focused medical education; license fee increase from $80 to $110 for physician medical license and a physician 65 or over and not affiliated with a hospital will pay $55.

MIIENJ Report . . . Noted the following: MSNJ is taking a leadership role with respect to medical malpractice tort reform; and the wrongful death bill (permitting any family member to bring suit following a death due to medical negligence) has been referred to the Department of Insurance for an estimate of impact on insurance rates.

JEMPAC and MEDAC . . . Noted that JEMPAC and MEDAC contributions have resulted in positive accomplishments and letters asking for funds will be mailed out shortly.

Unfinished Business . . . Changed position on S-2605 (occupational therapy licensing act) to no action. □

UMDNJ NOTES

Chandler Center gains federal designation. The Eric B. Chandler Health Center in New Brunswick, operated by UMDNJ-Robert Wood Johnson Medical School, has been designated a federally qualified health center by the United States Health Care Financing Administration. The Eric B. Chandler Health Center is the area's primary community health center, providing medical, dental, and social services for more than 5,000 poor, underinsured, and medically indigent residents in the New Brunswick area.

AIDS study reveals risks for women. Female intravenous drug users double their risk of getting the AIDS virus if they have more than one heterosexual partner, according to research at UMDNJ-New Jersey Medical School, Newark. The women face the risk of contracting the HIV virus either from unprotected sexual intercourse or sharing contaminated needles. Sexual transmission of the AIDS virus from

male to female appears to occur more easily than from female to male. The study was led by Dr. Stanley H. Weiss, associate professor of preventive medicine and community health.

Knee surgery. Twice as many women are undergoing surgery to repair injured knees now than ten years ago, according to a study by orthopedic surgeons at UMDNJ-Robert Wood Johnson Medical School.

Surgeons attributed the sharp increase to the success of arthroscopic surgery and the increased number of women participating in recreational, high school, and college athletics. Also, more women are competing in contact sports that are hard on the knees such as lacrosse, field hockey, and basketball.

The study examined knee operations on 400 patients over the past ten years at Robert Wood Johnson University Hospital. Researchers found that, at the end of the ten-year period, half of the patients were women compared with just 25 percent when the survey began.

New technique repairs fractured femurs quicker. Orthopedic surgeons at UMDNJ-Robert Wood Johnson Medical School at Camden are using a new technique to repair badly fractured legs quickly and with minimal blood loss. They are using a supracondylar device—a metal rod that is inserted into the broken bone—to repair broken thighs. This new technique currently is being used at only one other medical institution in the United States.

Study focuses on hypertension control. People with high normal blood pressure could reduce their risk of further blood pressure elevation by losing at least nine pounds and reducing salt intake by a half-teaspoon a day, according to researchers at UMDNJ-New Jersey Medical School. The research, sponsored by the National Institutes of Health (NIH), was conducted at the medical school and nine other institutions. The three-year inquiry tested seven non-drug methods to prevent people with high normal blood pressure from getting worse. About 2,200 people participated in the nationwide study to discover the effectiveness of sodium restriction; weight reduction and exercise; stress management; and four supplements, calcium, magnesium, potassium, and fish oil.

Dr. Norman Lasser, professor of medicine, directed the study at UMDNJ. A new research program now will test the results in a larger group over a longer period to determine if blood pressure is significantly reduced over time. It is the first long-term trial seeking to prevent hypertension in people who do not yet have the disorder.

New service for elderly starts in New Brunswick. A new Geriatric Assessment Service, designed to achieve optimum health care and independence for the elderly, has been initiated by UMDNJ-Robert Wood Johnson Medical School. The service, directed by Dr. Elaine Leventhal, employs a team of specialists to create an individualized plan to reduce chronic illness and increase patient self-reliance. The team includes a nurse practitioner specializing in geriatrics and a social worker. Psychologists, psychiatrists, neurologists, and nutritionists also are available for consultation. ☐ Stanley S. Bergen, Jr, MD, President

MSNJ AUXILIARY

There is more to Drumthwacket than just being the governor's residence. A private tour, sponsored by the Medical Society of New Jersey Auxiliary, was a success as 40 members were guided through the six public rooms of New Jersey's executive mansion.

Though the MSNJ Auxiliary spends the majority of its time and energy on health-related issues, legislation affecting the medical profession, and public relations, the group organized a recreational activity as a way for members to see a bit of New Jersey history, and get acquainted informally before beginning new projects for 1991.

The original section of the Drumthwacket Estate with its six Ionic columns was built in 1835 by Charles Olden. After amassing a large sum of money from his nine years of work in New Orleans with his partner, Mr. Tulane, Charles Olden returned to New Jersey and created one of Princeton's grandest Greek Revival mansions. During his lifetime, Mr. Olden served as state senator, judge, treasurer and trustee of Princeton University, and as the 28th governor of New Jersey. (Mr. Olden was born in the small white house that stands on the edge of Drumthwacket; he died in his mansion in 1876 at the age of 77.)

Moses Taylor Pyne bought the mansion from Mr. Olden's widow in 1893. Mr. Pyne added the impressive east and west wings to the estate and gave the home on 300 acres its name, "Wooded Hill." Pyne spent 20 years renovating the inside of the house including the Gothic wood-paneled library and also adding the park-like landscaping and multi-level



Drumthwacket, on Route 206 in Princeton.

formal Italian gardens. The gardens were created by landscape architect Daniel Langton to represent the 15th century Italian gardens popular at the turn of the century. Mr. Pyne was a benefactor, alumnus, and trustee of Princeton University and is remembered for establishing Collegiate Gothic architecture at the University campus.

After Mr. Pyne's death, the house was bought by Abram Spanel in 1940, a chemist and inventor, who continued to modernize the estate; in 1967, Mr. Spanel sold the mansion to the state of New Jersey. In 1981, the Drumthwacket Foundation was created to refurbish and furnish the mansion. The Foundation now oversees the 11 acres and the restoration of the home. Rooms have been decorated with period pieces from New Jersey craftsmen, including a number of tall case clocks, settees, as well as the silver service that was made for the battleship *USS New Jersey* and china noting "liberty and prosperity" (from the state seal) by Lenox.

The dining room features handpainted panels in green and orange with gibb doors (a reflection of Olden's southern influence), and a mahogany banquet table. The parlor displays New Jersey period piece furniture, paintings, and china. The music room boasts of Greek revival style with arches and moldings. The library, with its English paneling, features handpainted canvases on the ceiling; in this room a caen stone fireplace was carved for Mr. Pyne with pinecones and pinetrees and the motto, "In the storm, I will flourish." The final public room is the governor's study with an oval English partner's desk, rare books, a French shelf clock, and an oversized embroidered form highlighting the goldfinch, the violet, and the red oak. Persian rugs cover all the hardwood floors throughout the mansion.

Today, James and Lucinda Florio live on the second floor of the mansion, known as the official governor's home. ☐ Geraldine Hutner

PLACEMENT FILE

The following physicians have written to the executive offices of MSNJ seeking information on possible practice opportunities in New Jersey. These physicians wish to relocate to or within New Jersey in the coming months.

The information listed below has been supplied by the physicians. If you are interested in any further information concerning these physicians, we suggest you make inquiries directly to them.

Anesthesiology

Michael Silverberg, MD, 2020 Walnut St., Apt. 29K, Philadelphia, PA 19103. Yale 1983. Board eligible. Group or hospital. Available July 1991.

Cardiology

George D. Birmingham, MD, 3531 Salerno Ct., Apt. 5, Middleton, WI 53562. Mount Sinai 1984. Board eligible. Board certified (IM). Group or partnership. Available July 1991.

Internal Medicine

Won-Kook Chung, MD, 70 Hampshire Dr., Plainsboro, NJ 08536. Catholic Medical College (Korea). Board eligible. Group or solo. Available July 1991.

Thomas P. Hooker, DO, 2804 Sitios St., Tampa, FL 33629. Philadelphia College of Osteopathic Medicine 1984. Board certified; also, PUL. Solo or multispecialty group. Available July 1991.

Marc Kesselhaut, MD, 1 Rustic Ridge, C16, Little Falls, NJ 07424. St. George's University 1986. Board eligible. Solo or partnership in Mercer, Somerset, Burlington, Hunterdon, or Middlesex counties. Available.

Pathology

Charles F. Romberger, MD, 4501 Park Glen Rd., #241, St. Louis Park, MN 55416-4874. Temple 1986. Board eligible. Partnership or group. Available.

Pediatrics

Donna Churlin, MD, 55 Montgomery St., Bloomfield, NJ 07003. UMDNJ 1987. Board eligible. Partnership or group in Essex, Union, or Morris counties. Available July 1991.

Urology

Jeffrey L. Gevirtz, MD, 400 Narragansett Pkwy., Apt. SC7, Warwick, RI 02888. UMDNJ-Robert Wood Johnson Medical School 1986. Board eligible. Group or partnership. Available July 1991.

S. Misra, MD, 8161 Gatewood Dr., Clay, NY 13041. SCB-Orissa (India) 1977. Board eligible. Group or partnership. Available July 1991. ☐

ARE YOU MOVING?

If so, please send a change of address to *NEW JERSEY MEDICINE*, Medical Society of New Jersey, Two Princess Road, Lawrenceville, NJ 08648, at least six weeks before you move.

Name _____

Old Address _____

City _____ State _____ Zip _____

New Address _____

City _____ State _____ Zip _____

HU

Hahnemann University

Department of Medicine Grand Rounds 8:30 a.m.-9:30 a.m.

April 1991-May 1991

APRIL 1991

April 3, 1991

AN UPDATE OF GENE THERAPY
William N. Kelley, MD
Executive Vice President of the University of Pennsylvania
CEO, University of Pennsylvania Medical Center
Dean, University of Pennsylvania School of Medicine

April 10, 1991

NEW OPTIONS IN HEART FAILURE THERAPY
Marc A. Pfeffer, MD, PhD
Cardiovascular Division
Brigham and Women's Hospital
Boston, Massachusetts

April 17, 1991

RHEUMATOLOGIC ADVANCES
William J. Koopman, MD
H.L. Holley Professor of Medicine
Director, Division of Clinical Immunology and Rheumatology; Director, Multipurpose Arthritic Center
University of Alabama/Birmingham

April 24, 1991

ANTIHYPERTENSIVE THERAPY: BENEFITS BEYOND BLOOD PRESSURE CONTROL
Randall Zussman, MD
Assistant Professor of Medicine
Director, Division of Hypertension and Vascular Medicine
Massachusetts General Hospital
Boston, Massachusetts

MAY 1991

May 1, 1991

CHRONIC BRONCHITIS: A SYNDROME WE THOUGHT WE UNDERSTOOD
Stephen Rennard, MD
Larson Professor of Medicine
Section Chief, Pulmonary and Critical Care Medicine
University of Nebraska
Omaha, Nebraksa

May 8, 1991

THE LAW, THE HOSPITAL, THE PHYSICIAN: MEDICAL MALPRACTICE
Max Borten, MD, JD
Adjunct Professor of Law
Suffolk University Law School
Boston, Massachusetts

May 15, 1991

HEPATORENAL SYNDROME
Murray Epstein, MD
Professor of Medicine
University of Miami School of Medicine
Associate Director, Nephrology Section
Veterans Administration Medical Center
Miami, Florida

May 22, 1991

ADENOSINE: A NEW ANTIARRHYTHMIC DRUG
Bruce B. Lerman, MD
Director, Clinical Electrophysiology
Division of Cardiology
New York Hospital/Cornell Medical Center
New York, New York

May 29, 1991

CHOLELITHIASIS—NEWEST MEDICAL AND SURGICAL TREATMENTS
Teruo Matsumoto, MD, PhD
Professor of Surgery
Hahnemann University
Harris R. Clearfield, MD
Professor of Medicine
Director, Division of Gastroenterology
Hahnemann University

Hahnemann University Department of Medicine
Wednesday Medical Seminar Series
8:30 AM-3:30 PM

April 10, 1991
NEW OPTIONS IN HEART FAILURE THERAPY

April 17, 1991
RHEUMATOLOGIC ADVANCES

May 15, 1991
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Allan B. Schwartz, MD
Professor of Medicine
Director, Continuing Medical Education
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CONTINUING EDUCATION

ANESTHESIOLOGY

May

21 **Meeting**
6-9 P.M.—Ramada Inn, Clark
(NJ State Society of Anesthesiologists)

CARDIOLOGY

May

5 **International Association of Cardiac Biological Implants**
9 A.M.-5 P.M.—The Vista, Washington, DC
(UMDNJ)

June

26 **Clinical Arrhythmias**
1:30-2:30 P.M.—Runnells Specialized Hospital, Berkeley Heights
(AMNJ)

DERMATOLOGY

May

15 **Case Presentations**
6 P.M.—Rutgers Community Health Plan, U.S. Route 1, New Brunswick
(UMDNJ, Division of Dermatology)

23 **Common Dermatoses**
1:30-2:30 P.M.—Essex County Hospital Center, Cedar Grove
(AMNJ)

INFECTIOUS DISEASE

May

1 **Changing Concepts About**
7 **HIV Infection**
21 8:30 A.M.-1:45 P.M.—Taj Mahal (Atlantic City); Sheraton (Newark Airport); Sheraton Poste Inn (Short Hills)
(AMNJ and NJDOH)

3 **Diagnosis and Treatment of AIDS**
12 Noon-1 P.M.—South Jersey Hospital System, Bridgeton
(AMNJ and NJDOH)

8 **Diagnosis and Treatment of AIDS**
2-3 P.M.—Welkind Rehabilitation Hospital, Chester
(AMNJ and NJDOH)

10 **Identification and Management of HIV Infection**
12 Noon-1 P.M.—South Jersey Hospital System, Bridgeton
(AMNJ and NJDOH)

10 **Diagnosis and Treatment of AIDS**
10-11 A.M.—Marlboro Psychiatric Hospital, Marlboro
(AMNJ and NJDOH)

13 **Lyme Disease**
7-8 P.M.—Wallkill Valley General Hospital, Sussex
(AMNJ and NJDOH)

22 **Diagnosis and Treatment of AIDS**
10:30 A.M.-12 Noon—Christ Hospital, Jersey City
(AMNJ and NJDOH)

June

12 **Identification and Management of HIV Infection**
10:30-11:30 A.M.—Christ Hospital, Jersey City
(AMNJ and NJDOH)

15 **Prevention and Management of AIDS**
Robert Wood Johnson Medical School, New Brunswick
(UMDNJ)

19 **AIDS Update**
1:30-2:30 P.M.—57 U.S. Highway 1, New Brunswick
(Central New Jersey Medical Group and AMNJ)

MEDICINE

May

1 **Diabetes in Pregnancy**
10:30-11:30 A.M.—Christ Hospital, Jersey City
(AMNJ)

1 **Nephrotoxicity of Common Drugs**
10:30-11:30 A.M.—St. Mary's Hospital, Passaic
(AMNJ)

1 **Internal Medicine Review**
8 **Course**
15 4-7 P.M.—University Hospital,
22 New Brunswick
(AMNJ and UMDNJ)

2 **QA Criteria Development**
1:30-2:30 P.M.—Essex County Hospital Center, Cedar Grove
(AMNJ)

3 **Treatment of the Resistive Patient**
10-11 A.M.—Marlboro Psychiatric Hospital, Marlboro
(AMNJ)

5 **International Association of Cardiac Biological Implants**
9 A.M.-5 P.M.—The Vista, Washington, DC
(UMDNJ)

6 **Diabetic Retinopathy**
1-2 P.M.—New Lisbon Developmental Center, New Lisbon
(AMNJ)

7 **Internal Medicine Update and**
14 **Board Review**
21 5:30-7:30 P.M.—Cooper
28 Hospital/University Medical Center, Camden
(Cooper Hospital/University Medical Center)

8 **Arthritis**
10:30-11:30 A.M.—St. Mary's Hospital, Passaic
(AMNJ)

8 **Prevention of Lower Extremity Amputations**
9-10 A.M.—Elizabeth General Medical Center, Elizabeth
(AMNJ)

8 **Annual Meeting and 11th Annual Morris Saffron Lecture**
9 A.M.-2:30 P.M.—MSNJ Headquarters, Lawrenceville
(Medical History Society of New Jersey)

9 **Prehospital Coronary Care**
10-11 A.M.—Hunterdon Developmental Center, Clinton
(AMNJ)

10 **Osteoporosis**
1-2 P.M.—North Princeton Developmental Center, Princeton
(AMNJ)

13 **Lyme Disease**
Wallkill Valley General Hospital, Sussex
(AMNJ)

PHILADELPHIA HEART INSTITUTE

Presbyterian Medical Center

Cardiology Update

designed for the physician and provides an intensive survey of the current status of clinical cardiology . . .

Wednesday, 1 May 1991

Geriatric Cardiology

Moderator: Bernard L. Segal, M.D.

3:00-3:30	What drugs to use and not to use in elderly patients	***Steven J. Nierenberg, M.D.***
3:30-4:00	The management of lipid disorders in the geriatric patient	***Gary J. Vigilante, M.D.***
4:00-5:00	Case Presentations	***Joseph Lemlek, M.D.***
	Panel Discussion	
	Norman Feinsmith, M.D.	***William Corin, M.D.***
	Mariell Jessup, M.D.	***Charles Gottlieb, M.D.***
	William P. Santamore, Ph.D.	***Howard Rosner, D.O.***

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15 **Organ Procurement**
10:30 A.M.-12 Noon—Christ Hospital, Jersey City
(AMNJ)

15 **Postoperative Toxic Shock Syndrome**
10:30-11:30 A.M.—St. Mary's Hospital, Passaic
(AMNJ)

21 **DiGeorge Syndrome**
8 A.M.—St. Joseph's Hospital and Medical Center, Paterson
(St. Joseph's Hospital and Medical Center)

28 **Prevention of Lower Extremity Amputations**
12 Noon-1 P.M.—Elmer Community Hospital, Elmer
(AMNJ)

29 **Physician Office Laboratory Workshop**
9 A.M.-4:30 P.M.—Center for Health Affairs, Princeton
(Soc. of Clinical Pathologists)

June

4 **Internal Medicine Update and**
11 **Board Review**
18 5:30-7:30 P.M.—Cooper
25 Hospital/University Medical Center, Camden
(Cooper Hospital/University Medical Center)

5 **Prevention of Lower Extremity Amputations**
10:30-11:30 A.M.—Christ Hospital, Jersey City
(AMNJ)

5 **Urinary Incontinence of the Elderly**
10:30-11:30 A.M.—St. Mary's Hospital, Passaic
(AMNJ)

5 **Substance Abuse in the 1990s**
1:30-2:30 P.M.—57 U.S. Highway 1, New Brunswick
(Central New Jersey Medical Group and AMNJ)

6-7 **Emergency Medicine Annual Meeting**
Trump Taj Mahal Casino Resort, Atlantic City
(American College of Emergency Physicians and AMNJ)

12 **19th Scientific Session**
8:15 A.M.-2 P.M.—Quality Inn, North Brunswick
(NJ Thoracic Society)

13-14 **Annual Meeting**
Trump Plaza Hotel and Casino, Atlantic City
(NJ Gastroenterological Society/NJ Society for Gastrointestinal Endoscopy)

19 **Hypertension**
10:30-11:30 A.M.—St. Mary's Hospital, Passaic
(AMNJ)

OBSTETRICS/GYNECOLOGY

May

1 **Diabetes in Pregnancy**
10:30-11:30 A.M.—Christ Hospital, Jersey City
(AMNJ and NJDOH)

6 **Diabetes in Pregnancy**
12 Noon-1 P.M.—Helene Fuld Medical Center, Trenton
(AMNJ)

10 **Osteoporosis**
1-2 P.M.—North Princeton Developmental Center, Princeton
(AMNJ)

24-25 **From Reproduction to Menopause**
Loews L'enfant Plaza, Washington, DC
(UMDNJ)

31-June 1 **Annual Meeting**
Trump Plaza Casino Hotel, Atlantic City
(NJ Obstetrical and Gynecological Society)

ONCOLOGY

May

10 **Tumor Board Conference**
11 A.M.-12 Noon—Wallkill Valley Hospital, Sussex
(AMNJ)

15 **Breast Cancer Update**
1:30-2:30 P.M.—57 U.S. Highway 1, New Brunswick
(AMNJ and Central New Jersey Group)

15 **Reception**
6:30-9:30 P.M.—The Manor, West Orange
(Head and Neck Oncology Section, AMNJ, and Radiation Oncology Section, AMNJ)

23 **Tumor Board Conference**
12 Noon-1 P.M.—Newcomb Medical Center, Vineland
(AMNJ)

June

5 **Annual Meeting**
All day—The Manor, West Orange
(Oncology Society of New Jersey)

14 **Cancer Committee/Tumor Board**
11 A.M.-12 Noon—Wallkill Valley Hosital, Sussex
(AMNJ)

27 **Tumor Board Conference**
12 Noon-1 P.M.—Newcomb Medical Center, Vineland
(AMNJ)

ORTHOPEDICS

May

1 **Office Orthopedics**
1:30-2:30 P.M.—57 U.S.

SPECIAL ISSUES

Addiction

Guest Editor:
George Mellendick, MD, MPH

Summer 1991

Sports Medicine

Guest Editor:
Paul J. Hirsch, MD

Fall 1991

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1991
LOCATIONS AND DATES:

• FT. LAUD.	Feb. 16-17	• CHICAGO	July 13-14
• SAN FRANCISCO	Mar. 23-24	• ST. LOUIS	Sept. 14-15
• NYC	April 20-21	• ATLANTA	Oct. 12-13
• WASHINGTON DC	May 4-5	• DISNEY WORLD	Nov. 16-17
• NASHVILLE	June 8-9	• NEW ORLEANS	Dec. 14-15

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- **A symposium designed for the general medical practitioner, orthopedist, neurologist, chiropractor, physical therapist and rehabilitation specialist. This program will expose the participant to the most recent, scientifically supported, conservative treatment approaches and review of current diagnostic procedures available.**

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The 7th Annual International Symposium on Acupuncture & Electro-Therapeutics will be held at Columbia University, School of International Affairs, 420 W. 118th St., N.Y. City, during October 17-20, 1991.

These meetings are co-sponsored by the International College of Acupuncture & Electro-Therapeutics & its official journal, Acupuncture & Electro-Therapeutics Research, The International Journal (published by Pergamon Press & indexed in 15 major indexing periodicals, including Index Medicus), Heart Disease Research Foundation; NY Pain Center; Electrical Engineering Dept., Manhattan College; Nordic Medical Acupuncture Society (Scandinavia); Schmerz Therapeutische Kolloquium (West Germany); Japan Bi-Digital O-Ring Test Assn.; Accredited toward Acupuncture Certification to practice acupuncture. Eligible for AMA CME Cat. I credit (about 40 credit-hours for the Symposium).

For information on meetings or submission or presentations of papers, contact Symposium Chairman, Prof. Y. Omura, M.D., Sc.D., 800 Riverside Drive (8-I) New York, NY 10032 Tel: (212) 781-6262 (10 am to 10 pm 7 days a week) or (212) 928-0658, Co-chairman, Prof. A.W. Cook, MD (516) 877-1821, or Bro. Michael Losco (212) 920-0162.

Highway 1, New Brunswick
(AMNJ)

PATHOLOGY

May

16-18 **Annual Meeting**
Hotel Hershey, Hershey, Pennsylvania
(NJ Society of Pathologists/ Pennsylvania Association of Clinical Pathologists)

PEDIATRICS

May

8 **Child Abuse—Neglect**
10:30 A.M.-12 Noon—Christ Hospital, Jersey City
(AMNJ)

30 **Pediatrics Update**
6:30-10 P.M.—Marriott Hotel, Saddle Brook
(Northern NJ Pediatric Society and AMNJ)

PULMONARY

May

15 **Grand Rounds**
11:30 A.M.-12:30 P.M.—Newcomb Medical Center, Vineland
(AMNJ)

June

19 **Grand Rounds**
11:30 A.M.-12:30 P.M.—Newcomb Medical Center, Vineland
(AMNJ)

PSYCHIATRY

May

1 **Treatment of the Resistive Patient**
10-11 A.M.—Marlboro Psychiatric Hospital, Marlboro
(AMNJ)

2 **Suicide over the Life Cycle**
12 Noon-1 P.M.—Carrier Foundation, Belle Mead
(Carrier Foundation)

9 **Secondary Mania**
12 Noon-1 P.M.—Carrier Foundation, Belle Mead
(Carrier Foundation)

9 **Influence of Child Analytic Work on the Adult Analyst**
8-10 P.M.—Hackensack Medical Center, Hackensack
(NJ Psychoanalytic Society)

16 **Mental Health Dollar: Where Does It Go?**
12 Noon-1 P.M.—Carrier Foundation, Belle Mead
(Carrier Foundation)

28 **Patient Care Monitoring**
1:30-3:30 P.M.—Trenton Psychiatric Hospital, Trenton
(AMNJ)

30 **Psychotherapy of Mania**
12 Noon-1 P.M.—Carrier Foundation, Belle Mead
(Carrier Foundation)

June

3 **Treatment of Narcissistic Personality Disorder in a Child**
8:15-10:15 A.M.—Nutley
(Essex Psychiatric Seminar and AMNJ)

4 **Tuberculosis**
1-2 P.M.—Trenton Psychiatric Hospital, Trenton
(Trenton Psychiatric Hospital)

5 **Cults**
All day—Carrier Foundation, Belle Mead
(Carrier Foundation)

6 **Treating Schizophrenia**
12 Noon-1 P.M.—Carrier Foundation, Belle Mead
(Carrier Foundation)

6 **The Boy Who Would Be King—Symbols and Transference**
8-10 P.M.—Hackensack Medical Center, Hackensack
(NJ Psychiatric Society)

13 **Case Conference**
12 Noon-1 P.M.—Carrier Foundation, Belle Mead
(Carrier Foundation)

14 **Mitral Valve Prolapse and Easting Disorders**
10-11 A.M.—Marlboro Psychiatric Hospital, Marlboro
(AMNJ)

20 **Conflict over Child Custody**
12 Noon-1 P.M.—Carrier Foundation, Belle Mead
(Carrier Foundation)

RADIOLOGY

May

16 **Radiology Meeting**
Saint Barnabas Medical Center, Livingston
(Radiology Society of NJ/ AMNJ)

SURGERY

May

2-5 **Fifth Annual Meeting**
Pittsburgh, Pennsylvania
(Eastern Vascular Society)

15 **Postoperative Toxic Shock Syndrome**
10:30-11:30 A.M.—St. Mary's Hospital, Passaic
(AMNJ)

12 **Same-Day Surgery**
10:30-11:30 A.M.—St. Mary's Hospital, Passaic
(AMNJ)

20 **Reconstruction Options after a Mastectomy**
5-6 P.M.—Shore Memorial Hospital, Somers Point
(AMNJ)

UROLOGY

May

1 **William P. Burpeau Award Dinner and Memorial Lecture**
7 P.M.—The Manor, West Orange
(Urology Section, AMNJ)

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IN MEMORIAM

SAMUEL BERG

At the grand age of 92, Samuel Berg, MD, passed away on December 15, 1990. Dr. Berg, born in New York City on February 1, 1898, received his medical degree from Bellevue Hospital Medical Center, New York, in 1921 and his New Jersey medical license in 1923. During his lengthy career, Dr. Berg maintained a practice in Newark, specializing in internal medicine; was on the staff of Newark Beth Israel Medical Center and Newark Eye and Ear Infirmary; served in the United States Army Medical Corps during World War II where he was a member of the first military medical team to study the effects of atomic radiation in Hiroshima and Nagasaki; and was a member of our Essex County component and of the American Medical Association. Dr. Berg devoted many years to his medical research on the after effects of the atomic bomb. Dr. Berg resided in Newark for over 40 years, retiring at the age of 82.

RIAZ A. CHAUDRY

Born in Lahore, Pakistan, in 1941, general practitioner Riaz Ahmed Chaudry, MD, died November 12, 1990. Dr. Chaudry received his medical degree from King Edward Medical College, Lahore, West Pakistan, in 1963. Dr. Chaudry interned at Mayo Hospital, Pakistan and St. Mary's Hospital, Milwaukee, Wisconsin, and served residencies at Louis A. Weiss Hospital, Chicago; MacNeil Memorial Hospital, Berwyn, Illinois; and VA Hospital, New York. In 1974, Dr. Chaudry earned his New Jersey and Michigan medical licenses. Dr. Chaudry was affiliated with Valley Hospital, Ridgewood and Wayne General Hospital. Dr. Chaudry was a diplomate of the American Board of Family Practice, and a member of the American Medical Association and of our Bergen County component. Dr. Chaudry resided in Teaneck.

IRVING EHRENFELD

At the grand age of 86, Irving Ehrenfeld, MD, a retired member of our Passaic County component, died on December 8, 1990. Dr. Ehrenfeld, an allergy and gastroenterology specialist, was the former director of medicine at General Hospital Center at Passaic and founder of Passaic Internal Medicine Group. Born in 1904, Dr. Ehrenfeld received his medical degree from New York University Medical Center in 1930; he completed an internship at Bellevue Hospital, New York, the following year. During his career of 53 years, Dr. Ehrenfeld was affiliated with General Hospital Center at Passaic; he was the first physician in the United States to use hospital outpatient facilities to teach self-care to diabetic patients. Dr. Ehrenfeld was a professor of gastroenterological radiology at New York University Medical School, New York, and was a diplomate of the American Board of Medicine and a fellow of the American College of Allergy and Gastroenterology.

HARRY E. GERNER

Golden Merit Award recipient Harry E. Gerner, MD, died on November 10, 1990, in Coconut Creek, Florida. Dr. Gerner was born in Jersey City on May 27, 1906. Dr. Gerner graduated with a medical degree from the University of Maryland School of Medicine, Baltimore, in 1930 and earned his New Jersey medical license in 1935. Dr. Gerner maintained a pediatrics practice in Jersey City and was on staff at Jersey City Medical Center, Christ Hospital, the former Margaret Hague Hospital, the former Fairmount Hospital, and the former Greenville Hospital, all in Jersey City. Dr. Gerner retired in 1981 and moved to Florida. Dr. Gerner was a diplomate of the American Board of Pediatrics, a fellow of the American Academy of Pediatrics, and a member of our Hudson County component and of the American Medical Association. During World War II, Dr. Gerner served in the United States Navy, stationed at a hospital in Guam.

ERNEST C. HILLMAN, JR.

Born in Orange on October 12, 1913, Glen Ridge resident Ernest Charles Hillman, Jr, MD, passed away on December 16, 1990. Dr. Hillman earned his medical degree from New York University School of Medicine, New York, in 1941 and completed an internship and residency at Bellevue Hospital, New York. Dr. Hillman served as president and vice-president of the Essex County Heart Association; chairman of the insurance program for our Essex County component; medical director at Mutual Benefit Life Insurance Company, Newark, for 30 years; chairman of the Glen Ridge Board of Health; and clinical assistant professor at UMDNJ, Newark. In addition, Dr. Hillman was associated with The Mountainside Hospital, Montclair; Presbyterian Hospital, Newark; Saint Barnabas Medical Center, Livingston; and UMDNJ-University Hospital, Newark. Dr. Hillman specialized in insurance and internal medicine. Dr. Hillman was a member of our Essex County component and of the Essex County Heart Association.

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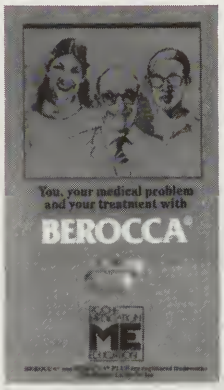
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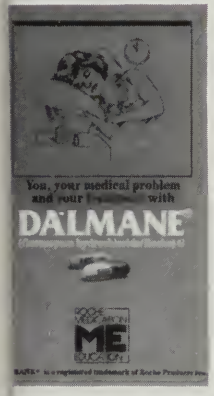


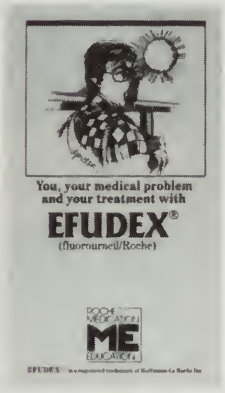
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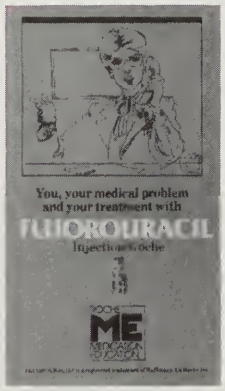
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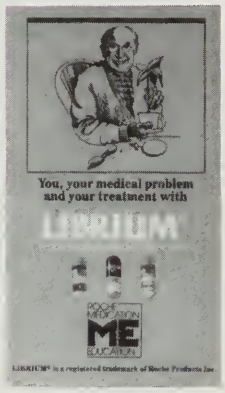
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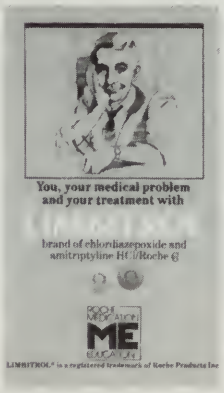
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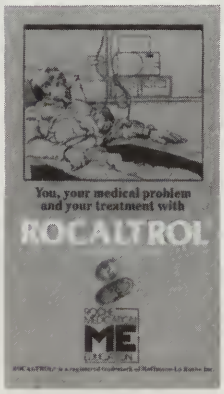




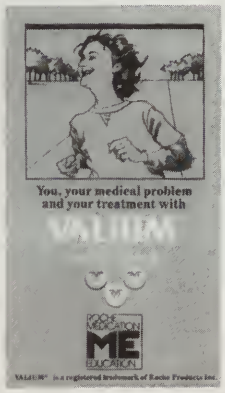












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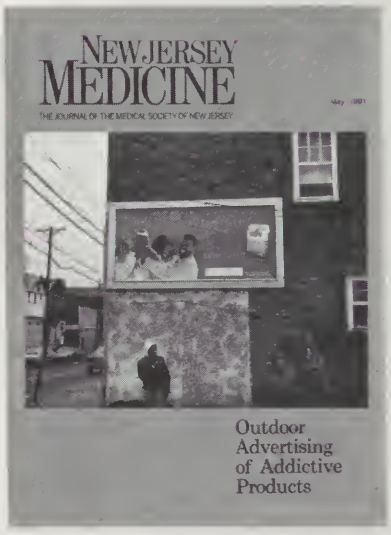
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The Cover

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MSNJ NEWSLETTER

PRESERVATION GRANT

A New Jersey State Library grant was awarded to the University Libraries' Special Collections Department, University of Medicine and Dentistry of New Jersey (UMDNJ) for the preservation of scrapbooks belonging to Harrison S. Martland, MD. Dr. Martland (1883-1954) was an important contributor to the fields of radiobiology, pathology and forensic medicine, industrial health, and oncology. The scrapbooks contain his research into the effects of radioactive materials in the human body; his work focused on the deaths of watch dial painters employed by a radium industry in Orange. Dr. Martland also conducted the first scientific study of the "punch drunk" syndrome suffered by prize fighters, a record of which also is in the scrapbooks. For additional information, contact Barbara Irwin, Project Director, UMDNJ–Special Collections, George F. Smith Library of the Health Sciences, 30 Twelfth Avenue, Newark, NJ 07103-2754.

EXTENDED CARE

The physician members of the Bergen County Medical Society voted unanimously to extend special financial consideration to the families of troops who served in Operation Desert Storm. The physician community wishes to show its support for our troops and understands the unusual financial circumstances. The American Red Cross also is available for referral purposes of any problems the families face.

HOSPITAL ADOPTS GULF UNIT

Shore Memorial Hospital, Somers Point, adopted the 15th Fleet Naval Hospital, a 500-bed combat zone trauma center as its sister hospital, marking the first time a civilian hospital has offered to adopt a fleet hospital deployed in the Gulf. The hospital plans to continue the program until the facility is decommissioned and the medical reservists return home. Shore Memorial Hospital physicians, nurses, and support staff have been exchanging letters and viodeotapes of news from home with members of the fleet hospital. Shore Memorial Hospital physicians also will supply military doctors with updated medical news from professional journals and other sources. "Caring for patients in any hospital under normal circumstances is difficult enough," according to Richard A. Pitman, president and chief executive officer of Shore Memorial Hospital. "The operation of a trauma center in a combat area placed even greater demands on hospital personnel. We wanted to support them in any way we could, as we became aware of their non-military needs."

MRI OWNERSHIP

Rep. Pete Stark (D-CA) has recommended restricting physician ownership of MRI facilities. Stark believes such ownership may result in referrals for unnecessary scannings. Reform could save the Medicare program $200 million a year.

POL WORKSHOP

A Physician Office Laboratory (POL) Workshop, sponsored by the American Society of Clinical Pathologists, will be held on May 29, 1991, at the Center for Health Affairs, Princeton. The program is open to medical personnel working in a POL and physicians who would like to learn more about POL management. The morning session is entitled, "Quality Control and Regulation for POLs," and the afternoon session is entitled, "OSHA Regulations and Safety Training for POLs." Further information can be obtained by calling, Kathleen Voldish, 609/428-8414.

ECG INTERPRETATION

A number of physician groups including the American Medical Association, the American Society of Internal Medicine, and the American Academy of Family Physicians have initiated a campaign to urge Congress to repeal a 1990 law eliminating Medicare coverage of electrocardiogram (ECG) interpretations effective January 1, 1992. The law proposes to end Medicare payment for "routine" ECG interpretations during an office visit or consultation.

PHOTOCOPYING FEUD

The five-year feud between hospitals and the Health Care Financing Administration (HCFA) over reimbursement for photocopying costs incurred for medical records copies requested by Medicare peer review organizations may be over. Both sides in the dispute, "Swedish Hospital vs. Sullivan," have agreed with a request by United States District Court Judge Louis Oberdorfer, that a mediator attempt to resolve the dispute. Hospitals want payment for copies provided from 1984 to 1987, as well as a $.05 per page increase over the $.05 rate paid by Medicare since April 1987.

HEALTH CARE FUND

A chief lobbyist for the business coalition has recommended elimination of the $218.5 million subsidies for mass transit and use of the funds to finance health care reforms. This would replace the proposed 1 percent payroll tax. The coalition contends that the mass transit subsidies for New Jersey residents that commute out of state provide no benefits to the state. The AFL-CIO has stated that the payroll tax "can very well be the life and death for union health and welfare funds and also life and death for the 60,000 individuals who buy their own health insurance coverage." It is estimated that if the surcharge used to fund the Uncompensated Care Trust Fund were renewed, the surcharge would rise from 19 to 25 percent.

NATIONAL DATA BANK

The American Medical Association House of Delegates has recommended that malpractice settlements of less than $30,000 should not be included in the new federal National Practitioner Data Bank, and that physicians be allowed to provide explanation of information included in reports prepared from these records. They also suggested that physician data be purged every five years, except where license revocation is involved.

MAMMOGRAM COSTS

Medicare has reinstated coverage for mammograms. Coverage previously was provided under the catastrophic coverage law, repealed in 1989. HCFA anticipates approximately 3 million women will receive mammograms as a Medicare benefit through the end of fiscal year 1991, at a program cost of $170 million.

PATIENT INSURANCE

According to a recent study reported in the *Journal of the American Medical Association*, uninsured hospital patients have higher mortality rates, shorter lengths of stay, and receive fewer costly tests as compared to insured patients. Mortality rates were one to three times higher for uninsured patients hospitalized in 1987 and are believed to be due to environmental and socioeconomic factors, e.g. deaths attributable to violence, homelessness. The fewer ordered tests, in many cases, were in response to patients wishes to avoid expensive, inconclusive tests. The study's findings appear to confirm the growing information supporting universal health insurance of some type.

DRUG MAKERS REDUCE HOSPITAL DISCOUNT

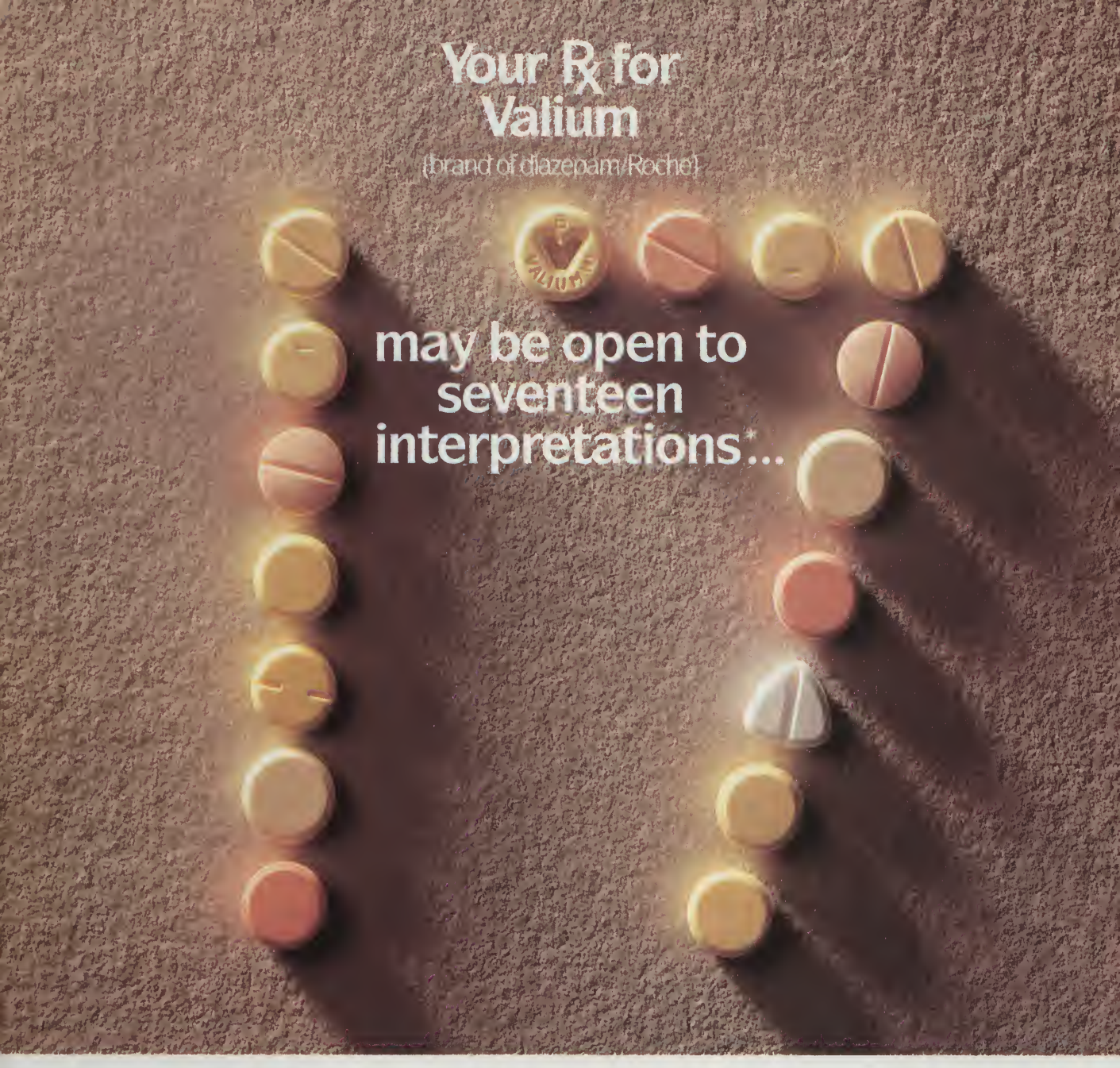
According to Senator David Pryor (D-AR), drug manufacturing companies are eliminating and reducing discounts traditionally given to hospitals, HMOs, and the VA. The discount reduction appears to be in response to a Pryor-sponsored provision in the new budget law that requires drug manufacturers to charge Medicaid the lowest market price. The elimination of drug discounts to hospitals would cost hospitals $400 to $700 million annually according to a recent study. According to Congressional members, the increasing of best price to Medicaid through the elimination of discounts is contrary to the anticipated intent of the law and may trigger more legislation aimed at lowering Medicaid drug/pharmaceutical expenditures.

PAYMENT SHORTFALLS

According to a report issued by the American Hospital Association, hospitals lost $4.3 billion treating Medicaid patients and provided $8.9 billion in uncompensated care during 1989. The study found that the combined shortfall from Medicaid and uncompensated services has increased almost 400 percent since 1980. The report estimated that Medicaid payments averaged 78 percent of the cost of providing services in 1989 compared to 90 percent in 1985. The report cited government funding constraints, the epidemic of drug abuse, and AIDS as causes for the increased shortfalls.

MALPRACTICE REFORM

Senator Orrin Hatch (R-UT) has proposed medical malpractice reform as one method of improving access to health care. Hatch estimates that defensive medicine practiced by physicians in response to increased malpractice litigation costs the consumer $19.3 billion in 1988. The proposed reform measure would offer grants to states to develop educational programs on preventing medical injuries, to limit noneconomic damages, and to reduce attorneys' contingency fees. □



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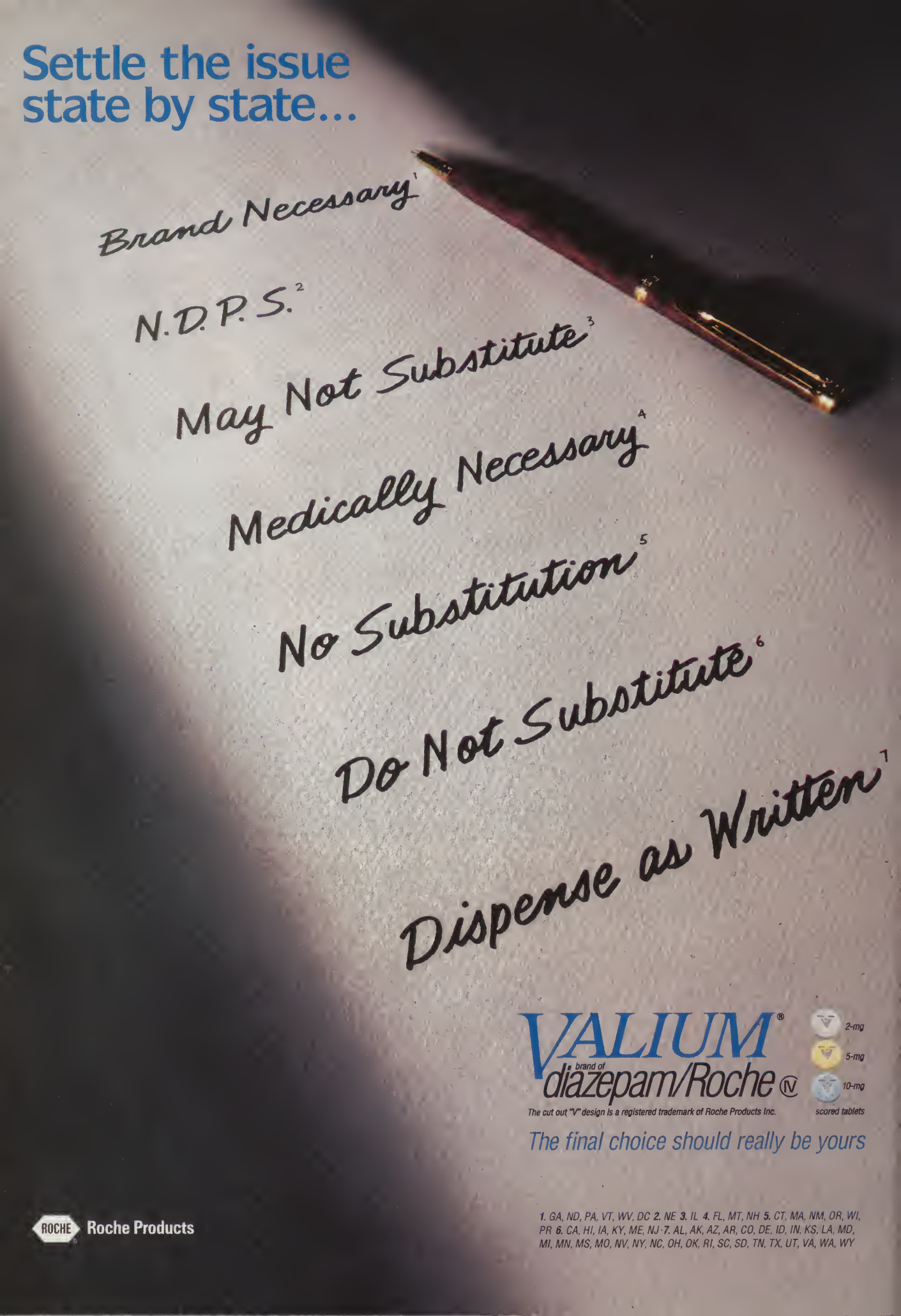
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PROFESSIONAL LIABILITY

THE FUTURE OF MEDMAL

If the past is a reliable predictor of the future, then the professional liability insurance field is due for a sharp change of course in the near future.

Washington formally has acknowledged that the nation is in a recession. International issues dominate the news; these developments will impact substantially on the price and availability of medical malpractice (medmal) insurance.

Brad Cohn, MD, president of the Physician Insurers Association of America, sees a new medmal insurance crisis developing. The San Francisco pediatrician, chairman of Medical Insurance Exchange of California, said: "Recession has a negative impact on physicians, hospitals, and carriers, just as it does on everyone else. What happens in the stock market significantly affects insurance companies. In the good times, these carriers make their money from investment income, not on the premiums they collect. When interest rates are high, companies seek more capital for investment purposes by lowering rates to attract more insureds."

Cohn said the scenario plays out like this: "In such a competitive market as we have been experiencing, companies have undervalued premiums—selling policies for less than they will have to pay out. Now investment income is going to go down as interest rates drop and companies will not be able to offset underwriting losses as they have been doing. Some companies will have to get out of the game. When that happens, we will have our next insurance crisis—like the one from 1981 to 1984—possibly in about two years, depending on how deep the recession is and how long it lasts."

Jack Rolig, St. Paul's underwriting vice-president in the Medical Services Division, is not a man to make predictions, but he did suggest that there are some general patterns that historically occur to trigger an alteration in the insurance cycle. One major change could be shrinkage of market capacity with a resulting increase in prices; he said, "When the economy is turning down, typically the investment market also turns down. If that happens, investors don't invest their capital in the insurance industry. When capital become short, the industry tends to reduce its capacity. Then we have a tight market, particularly in the more risky, less predictable lines."

Reduced capacity means carriers also lower limits for excess coverage. "Excess limits tend to go away. Insureds have to work very hard to get catastrophe coverage. On the lower end, that translates into higher prices," Rolig suggested.

Recession changes the elements in an insurance company's profitability picture. If investment income falls, unless a carrier can make up the shortfall by reducing losses or expenses, then additional investment income must be generated.

Can losses be reduced? Rolig said that the loss trend line has been going down in medmal but now has turned upward, although it is staying relatively flat. "Losses are the first primary determinant of prices," the St. Paul executive noted.

What about cutting expenses? Cohn said in the doctor-company setting, expenses already are minimized, with any profits being returned to insureds in the form of reduced premiums along with any dividends generated by good experience.

On the commercial side, Rolig pointed out that most of the expenses are fixed "people costs" that cannot be reduced significantly: "If investment income falls, you cannot generate capital and capacity shrinks, and you cannot reduce losses or expenses, then the only component you have that would affect revenues would be increased premium levels," he frankly admitted.

Will a tightening market—if and when it develops—lead to the downfall of some of the carriers now in the medmal market? Cohn said, "We have some very fragile companies out there and real problems will occur. But most PIAA companies have not dropped premiums to unrealistic levels in an attempt to attract investment income."

However, the quality of companies' portfolios could affect their fates, the PIAA president suggested: "Companies who speculated on investments could fall off the edge."

"The-hit-and-run companies are the ones I worry about. What happens during an economic slump when a company is put into receivership or is bankruputed? The attorney-in-fact and the management company walk away from it whole but the insureds get hurt," Brad Cohn stated.

In some states, policyholders would not be able to recover from state guaranty funds and their own personal financial assets could be on the line.

Cohn also said some risk retention groups could be particularly vulnerable in a deep economic slump; some, because they are assessible, could go back to policyholders for infusions of needed

funds, but few have access to guaranty funds in event a bailout is needed.

Rolig, too, said that in an economic downturn, companies become more susceptible to insolvency. However, he noted, "Proper investment policies make a company less susceptible."

"Companies that know how to play the game expertly and play it sensibly should come through this period with no trouble," said Cohn.

The San Francisco physician said that in one sense, doctor-owned companies have greater vulnerability in hard times because most stick to only one line—professional liability. That means the more fragile companies cannot lay off losses from the volatile medmal business to other lines, as can multi-line companies.

But Cohn stated doctor-companies have other things going for them, including policyholder loyalty, physician involvement in underwriting, claims review, and loss prevention. Many have been doing well and have been reducing premiums as well as returning initial capital loans and paying dividends to insureds.

Offsetting the flight of capital from risky lines like medmal, according to Rolig, is the fact that so much of the professional liability insurance is written by specialty carriers, like doctor-companies.

It is their only business. As a result, in tough times they may have to struggle for capital, but they are able to get it because they are doing what they do best. But it does become more difficult.

Rolig suggested that, from his perspective, the ability to react rapidly is extremely important when economic times are changing. He stated that if a changing environment points to the need for premium increases, then companies writing in states in which such increases can be effected quickly will fare better than companies writing in states where it takes longer. (Reprinted from *Medical Liability Monitor*, January 29, 1991.)

ALTERED MEDICAL RECORDS

A professional liability insurance company did not violate a statute governing cancellation of insurance when it cancelled a physician's insurance policy for alteration of patient medical records, a Maryland appellate court ruled.

On March 4, 1982, a 24-year-old patient went to the physician to have a wart removed from his thumb. The physician removed the wart and a black lesion on the patient's left leg. The physician's secretary prepared a billing record for the patient showing excision of the wart and the lesion. It did not reflect the fact the physician removed the lesion and a section of tissue around it. A pathological examination confirmed the physician's suspicion: the lesion was cancerous. He gave the patient a copy of the pathological report at a followup visit.

Five months later, the patient began to experience swelling in his left groin area. Another physician diagnosed disseminating cancer. A surgeon later removed a malignant lymph node from the patient's groin. A month later a surgical oncologist performed a resection of the original excision of the lesion on the patient and removed a noncancerous lymph node. The surgeon contacted the first physician and indicated that the excision on the patient's left leg seemed to be much larger than the 20 x 10 mm stated in the pathology report.

After discussion with the pathology laboratory, a revised pathology report was issued. It stated that the entire specimen was 18 x 7 cm and the portion mentioned in the original report was a deeply pigmented, slightly elevated lesion in the center of the specimen.

The patient's attorney requested copies of the patient's medical records and bills. Instead of sending copies of the original records, the physician sent the attorney copies of the amended pathology report and a billing record prepared 21 months after the patient's visit. The billing record described the excision as 18 x 7 cm and recommended the patient see another physician for followup care. The physician sent a different version of the billing record to his insurance company. He did not mention the existence of the original billing record nor mention the billing record submitted was not prepared at the time the patient was treated.

After a hearing, a Health Claims Arbitration Panel determined that the physician was liable for negligence in failing to properly excise the malignant melanoma with sufficient margins to prevent recurrence. The Panel awarded the patient $650,000 in damages. During the hearing the physician testified that none of the three billing records was accurate.

The physician's insurance company then cancelled his coverage for alteration of records. The insurance commissioner concluded that the company improperly cancelled his insurance and ordered the company to continue to insure the physician. A trial court reversed.

Affirming the decision, the appellate court said that cancellation of the insurance policy for altering patient medical records was reasonably related to the insurance company's economic and business purposes. The company satisfied the statutory requirements for cancellation of the policy. (Reprinted from *The Citation*, Vol. 62, No. 5, December 15, 1990.)

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EDITOR'S DESK



OBSCENITIES

The scientific community is in agreement; smoking kills. The statistics are clear-cut and revealing. Dr. Louis Sullivan, head of the United States Department of Health and Human Services reported that smoking costs about $1 billion a week in economic losses. And Americans die from the effects of smoking at a rate of 300,000 and 435,000 people per year. It also is estimated that about 2.5 million premature deaths occur worldwide from the use of tobacco. An editorial in the March 28, 1991, issue of *The New England Journal of Medicine* dramatizes the nefarious influence of the United States tobacco industry on other countries, especially the developing ones. Unfortunately, the efforts of these companies have been abetted by the United States Trade Office, that has opened the markets abroad by threatening trade sanctions; as a result, smoking overseas has increased radically, especially in young people and in women. The tobacco industry spends over $1 billion on advertising, including the print media and billboards, and over $2 billion on various promotions.

The campaign against these companies and their advertising has originated at many levels and from varying sources and has accelerated through the years. The American Medical Association, finally resisting the opposition from delegates primarily from tobacco-producing states, has called for a complete ban on advertising. The American Public Health Association has decried the "obscene profitability" of the tobacco companies and recommended divestitures of their equities. Legislators have proposed draconian measures against advertising of all types and smoking has been restricted in many places. The Doonesbury cartoon has ridiculed the longstanding tradition of giving freebie cigarettes to military service personnel. Taiwan has started a campaign to target the health risks of smoking and no longer will give free cigarettes to its soldiers, and, despite large tax revenues, will change the name of the most popular cigarette, the "Long Life." ("Quick Death" or "Coffin Nail" would be appropriate.) We have added our own voices via articles and editorials in *NEW JERSEY MEDICINE*. Dr. Everett Koop, who keeps spearheading the efforts toward a smoke-free society, merits continuing applause.

There is no doubt that some of the restrictions on advertising and the campaigns have had some effects; there are increasing numbers of exsmokers in the United States. But, if present consumption continues, five million children now alive in this country will die from tobacco-related illnesses. The cost to the consumers abroad already has been noted. The targeting of advertising to special groups also has been noted in the past. The article in this issue of *NEW JERSEY MEDICINE* (pages 331-333), although it

may not be statistically convincing to some, is another example of this trend.

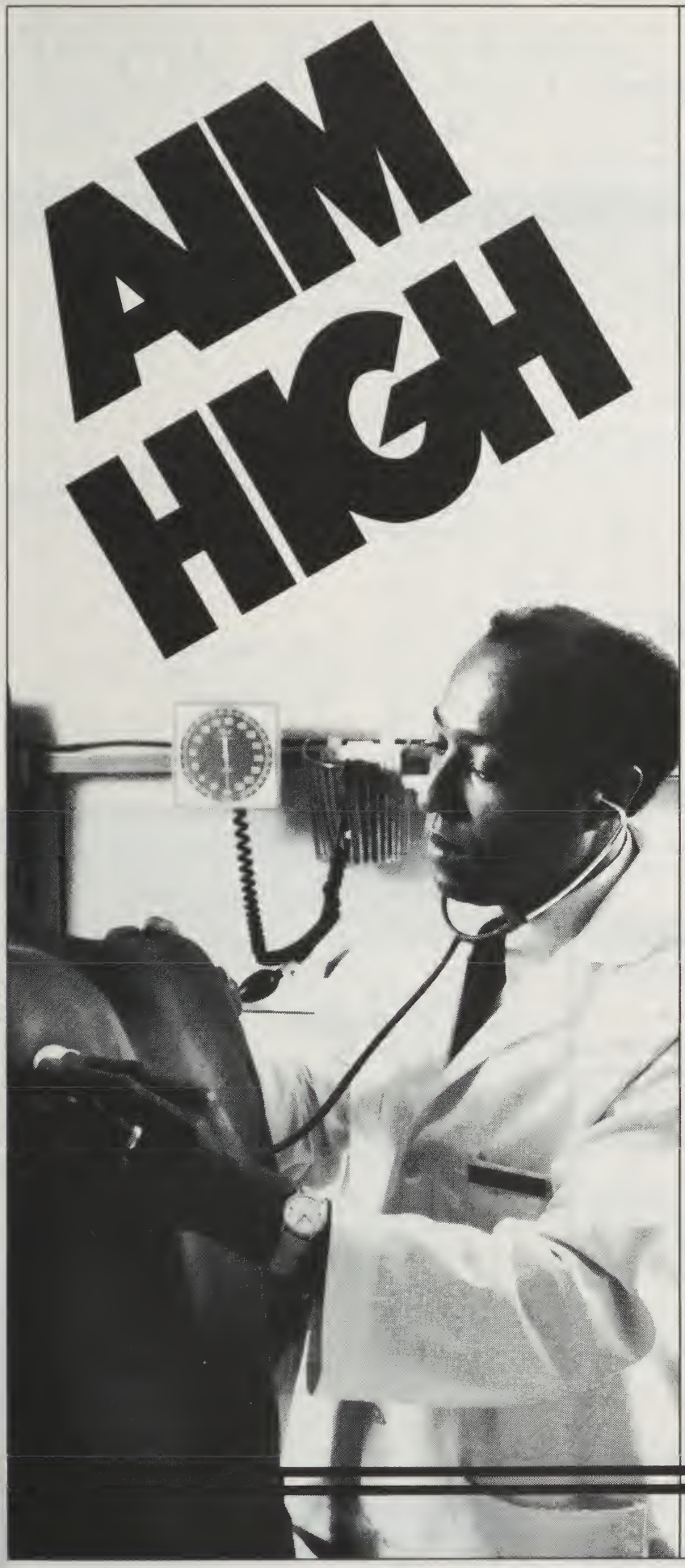
We previously have helped to call attention to the unfortunate association of cigarettes and sporting events and asked that athletes divorce themselves from such hypocrisy. Now we have the report of the Seventh World Conference on Smoking and Health, presented in Perth, Australia, April 3, 1990, and reviewed in the March 28, 1991, issue of *The New England Journal of Medicine*. The report delineates the extent tobacco products are promoted at the extremely popular automobile, motorcycle, and truck races and competitions in this country—widely covered on television. It notes that strict application of the Public Health Smoking Act of 1969, prohibiting the television activity of cigarette brands, could saddle Marlboro with a fine of about $60 million for just one event, thus effectively curtailing such activities. It also suggests that a favorable precedent may have been set by the Australian Supreme Court in 1990, when it ruled that such telecasts are cigarette advertisements and, therefore, are banned.

As expressed in *The New York Times* of March 28, 1991, the Philip Morris companies, the world's largest consumer products company and the maker of Marlboro cigarettes, named a non-tobacco man as its new chairman and chief executive officer, effective September 1, 1991. The article also points out the developmental changes in Philip Morris. In 1985, it made almost all its money from cigarettes and beer. Last year, half its $51.2 billion revenue came from food products, but 70 percent of its profits came from tobacco, much from abroad. Lest anyone worry, the outgoing chairmen of the company stated that the new chairman "is prepared to defend the tobacco business" from increasing onslaughts of anti-smoking advocates. And the incoming chairman agreed, saying the cigarette business "is great, profitable, and growing, so it looks like the future to me," adding, "If there has ever been a company that looked like it didn't need fixing, Philip Morris is it."

So we cannot look to the tobacco companies to "do the right thing." They will not even concede the relationship between smoking and disease. Maybe the United States Supreme Court, in reviewing the landmark case against tobacco companies that originated in this state, will make the tobacco industry unprofitable. Perhaps the law banning cigarette advertising on television also can ban sponsorship of sporting and cultural events. This has been done in Australia, New Zealand, and Canada and, according to the evaluation of the Office of the General Counsel of the American Medical Association, could be accomplished legally in this country as well. Although we all must have concerns about the trade deficits this country has absorbed for too long, it is not appropriate for us to improve the balance on the bodies of the dead and dying smokers we have created overseas. Finally, it would be appropriate for us to divest ourselves of the stocks of these merchants of death, even though they may have diversified into more healthful products. And those of us who teach and believe in preventive medicine and health should lead the way. □

As a single leaf turns not yellow but with the silent knowledge of the whole tree, so the wrong-doer cannot do wrong without the hidden will of you all. Kahlil Gibran, *"On Crime and Punishment," The Prophet (1923).*

Howard D. Slobodien, MD



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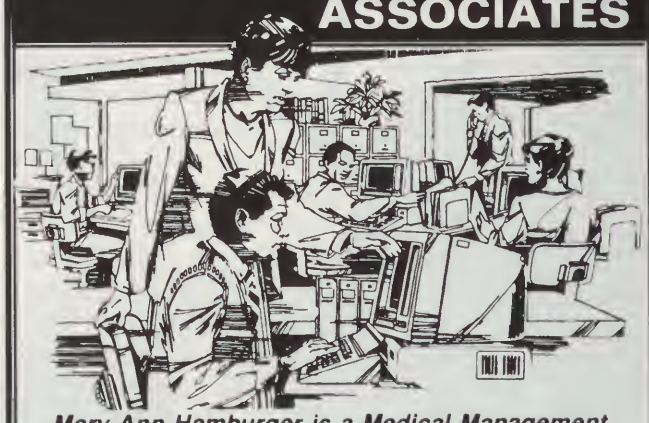
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BOOK REVIEWS

RADIATION ONCOLOGY

Hassan K. Awwad. Norwell, MA, Kluwer Academic Publishers, 1990. This ambitious monograph, written by a single author, promises to cover the boundary zone between clinical radiotherapy and fundamental radiobiology and physiology. The book, a hardbound volume of 682 pages, presents a unique format consisting of four parts divided into several chapters, with a brief summary ushering each chapter. The book follows a certain logic, beginning with basic molecular and cellular radiobiology, gradually building up the information for effects on tissues, early and late, and the influence of dose, time, and volume on the resulting effects as well as the interaction of clinically relevant chemotherapeutic agents on these effects. The last part of the book is devoted to radiation response of tumors. The text is well illustrated with useful diagrams. But it also is mined with a plethora of theoretical models and mathematical formulas that might turn off the noninitiated reader. One wonders whether the book would have been more useful and usable had it been less ambitious. At least the author's promise to cover the boundary-zone would have been fulfilled. In spite of its shortcomings, the book is recommended to radiation oncology residents for selective reading before taking the first part of their Board examinations, and to radiobiology teachers and their students. It also is recommended to practicing radiation and medical oncologists for answers to unusual clinical questions. □ Ismail Kazem, MD

VENOUS THROMBOEMBOLIC DISORDERS

A. Leclerc; R. Jacques. Philadelphia, PA, Lea and Febiger, 1991. This new entry to the literature on venous thromboembolism emanates from the division of hematology and clinical epidemiology in the department of medicine at McGill University, Montreal, Canada. This highly respected group of authors has made definitive contributions in this field. Detailed information regarding the process of hemostasis and coagulation is presented. These chapters could be used as a current review of the literature. The pathophysiology of thrombosis and subsequent embolization are reviewed. Diagnosis, treatment, and prophylaxis also are covered. Separate chapters are devoted to innovative new treatment modalities including both unfractionated and low-molecular weight heparin. The contributions on epidemiology include a series of recommendations for critical evaluation of the thromboembolic literature. The text concludes with several chapters devoted to more specific problems, i.e. clinical treatment of venous thrombosis in pregnancy, pediatrics, the cerebrum, and the retinal vein.

The material is comprehensive, and, thus, is intended to guide the reader in development of a well-thought-out management plan for venous thromboembolism. Conveniently, the chapters are organized under headings of specific clinical questions followed by discussion of the relevant data. However, there is a remarkable paucity of discussion regarding surgical treat-

ment. In my opinion, this is the major weakness of this text. For example, there is little guidance for treatment of one of the more common presentations of this disease occurring in the postoperative period.

In summary, this book provides a comprehensive review of most aspects of venous thromboembolic disease and acts as a superb clinical and research reference source for medical therapy. ☐ Frank T. Padberg, Jr, MD

THE VISIBLE HUMAN BODY

Gunther Von Hagens; Lynn J. Romrell; Michael H. Ross; Klaus Tiedemann. Philadelphia, PA, Lea and Febiger, 1991. This joint effort from the Universities of Heidelberg and Florida has produced a first-rate depiction of gross anatomy. In keeping with the use of current cross-imaging modalities, the editors have incorporated pertinent pictures of state-of-the-art computed tomography and magnetic resonance (MR) imaging scans. Since MR imaging often is achieved in multiple planes, the editors have taken care to portray anatomical sections in accordance with the most commonly used views. In addition, body slices are photographed with vivid resolution. Attention to these details yields a cohesive, realistic image of the three-dimensional aspects of the human body. The contents of the atlas are divided into the following sections: head and neck, upper extremity, thorax, abdomen, male pelvis and perineum, female pelvis and perineum, and lower extremity.

The oversized book of 150 pages is a handy reference guide for the physician, medical student, and technologist. ☐ Neil B. Horner, MD

CARDIAC CATHETERIZATION

William Grossman, MD; Donald Bain, MD. Philadelphia, PA, Lea and Febiger, 1990. The fourth edition of this well-known standard reference text by Dr. Grossman provides a comprehensive knowledge base regarding cardiac catheterization with major revisions focused on the newest interventional methodologies in the treatment of coronary artery disease. A second editor, Dr. Donald Bain, has been added and there are nine new contributors to the text.

The first four sections of the book cover: general principles of cardiac catheterization and angiography, techniques of cardiac catheterization, hemodynamic principles, and angiographic techniques. The fifth section contains the first four chapters of the third edition; the sixth section covers special catheter techniques. A new section representing the major revisions to the third edition reviews interventional techniques and has chapters on coronary angioplasty, atherectomy, stents, lasers, balloon valvuloplasty, and pediatric interventions. The eighth section remains essentially unchanged and profiles specific disease groups with very practical discussions.

Illustrations and tables are of excellent quality with clearly understood captions. The font remains unchanged. There is a 0.5 mm wider spacing between lines of the text that enhances ease of reading. The paper is glossy, but only minimal glare is noticed. The bibliography for each chapter is extensive with references as recent as 1989. Between the table of contents and index, the reader can identify rapidly the location of any subject. This book probably is the premier text for teaching cardiac catheterization but remains a valuable reference source for health care practitioners as well. ☐ Robert M. MacMillian, MD

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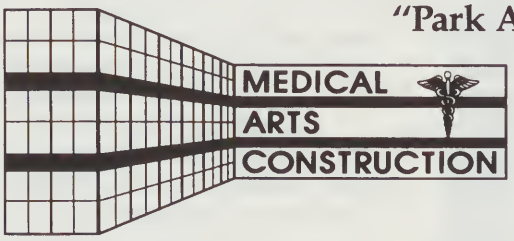
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Outdoor Advertising of Addictive Products

Olivia Mitchell, MA
Michael Greenberg, PhD

Billboards in black and Hispanic neighborhoods in four selected New Jersey cities disproportionately contain advertisements for tobacco and alcohol products and are designed with images of sex, youth, and affluence to promote the use of addictive products.

Tobacco and alcohol-related diseases are a national public health problem associated with 600,000 deaths annually from heart disease, cancer, cirrhosis, accidents, homicide, birth defects, emphysema, malnutrition, other diseases, and violent causes of death.[1,2] Black Americans suffer disproportionately from the hazardous relationship between smoking, alcohol abuse, and morbidity.[3,4]

Targeting of minority communities by the tobacco and alcohol industries is controversial, illustrated by the aborted effort of R.J. Reynolds to market "Uptown" cigarettes to blacks.

The use of billboards in minority neighborhoods is particularly controversial.[5-11] Observers report that cigarette and alcoholic beverage advertisements are more prevalent in black and Hispanic neighborhoods than in non-Hispanic, white neighborhoods.[12-15] These studies are inconclusive, however, because blacks and Hispanics disproportionately live in inner-city areas where there are many billboards. The concentration of cigarette and alcohol advertisements reported in minority neighborhoods may simply be caused by the concentration of billboards. Minority communities also may have many benevolent or, at least, nonmalevolent billboard advertisements. This possibility leads to the following question: Compared to white neighborhoods, do billboards in minority neighborhoods disproportionately feature addictive behaviors? The effort to target minorities also is not clear. Researchers say that billboards in minority communities appeal to youth, affluence, and sex in an effort to attract young people. But there is no evidence that this is not the case in other communities. This uncertainty leads to a second research question: Do billboards in minority communities use racial/ethnic-specific language and models more than billboards in non-Hispanic, white neighborhoods? The purpose of this paper is to present the results of a survey of four New Jersey cities that answered these two questions.

METHODS

Because blacks and Hispanics are relatively poor, we surveyed every block in four communities that contains poor and lower middle-class black, Hispanic, and non-Hispanic, white neighborhoods. Perth Amboy, New Brunswick, South Amboy, and Paterson were chosen as study cities. The combined population of the four cities was 226,000 in 1980. Twenty-eight percent of the population was black, 27 percent was Hispanic, and nearly all of the remaining 45 percent was non-Hispanic white. The median family income was 68 percent of the New Jersey median, and 19 percent of the population was reported by the United States census to live in poverty; this compares to 7.6 percent of the New Jersey population living in poverty.

Billboards included advertisements placed on the sides or roofs of buildings or freestanding in lots or roadways, posters placed on convenience stores, freestanding sidewalk sandwich boards, and five-foot billboards designed specifically for pedestrians to view. We observed two types of addictions advertised on billboards: cigarettes and alcohol (including liquor store locations, that almost always had alcohol advertised on the billboard). We also observed billboards advertising clothing stores, soft drinks, restaurants, medical services, vacations, insurance, and other goods and services that, if not benevolent, were not obviously malevolent.

We used United States Bureau of Census tract statistics to determine the racial/ethnic en-

vironment of every billboard. Billboards considered black/Hispanic were located in census tracts with at least two-thirds black and Hispanic residents. White billboards were determined by location in a census tract that had two-thirds or more non-Hispanic, white residents. The remaining billboards were classified as located in mixed neighborhoods.

A visual content analysis of cigarette billboards also was made. We classified a billboard as targeted to blacks/Hispanics if it featured a black or Latin model and/or the Spanish language. A billboard targeted to non-Hispanic whites featured a white model and English language. Billboards that used English and did not feature a model were classified as neutral.

RESULTS

Table 1 shows that 478 billboards were identified. Paterson and South Amboy had 1 billboard for about every 400 residents compared to 1 billboard for every 800 residents in New Brunswick and Perth Amboy.

Sixty-six percent of the billboards (315 billboards) were classified as advertising addictive products and services. Seventy-six percent of billboards in black and Hispanic neighborhoods featured addictive behaviors compared to 62 and 42 percent in the mixed and non-Hispanic, white communities, respectively. More than half of the advertisements in minority communities were for cigarettes compared to 46 percent in mixed neighborhoods and 35 percent in white neighborhoods. Black/Hispanic neighborhoods also had a much higher percentage of alcohol advertisements (22 percent) than white neighborhoods (7 percent). Conversely, black/Hispanic areas had a relatively small proportion of nonaddictive advertisements (24 percent) compared to non-Hispanic, white neighborhoods (58 percent) and mixed communities (38 percent).

The visual content analysis of the 231 cigarette billboards showed that 71 percent of billboards in black/Hispanic neighborhoods used models and language clearly targeted to blacks and/or Hispanics compared to only 25 percent in non-Hispanic, white neighborhoods that used white models and English language to target whites (Table 2). In other words, cigarette advertisements in minority neighborhoods appear to be obviously more targeted than those in other neighborhoods. To underscore this point, we observed that 6 of the 20 cigarette billboards in non-Hispanic, white neighborhoods featured black or Latin models or Spanish language compared to only 5 of the 20 cigarette billboards that featured white models and English.

The most striking impression of the visual content analysis was the contrast between young, affluent, attractive blacks and Hispanics featured in cigarette advertisements and the absence of this same population on nonaddictive billboards. Of the 163 nonaddictive billboards, fewer than 5 billboards clearly featured black or Hispanic models. In contrast, nonaddictive advertisements for health services typically featured white families (parents, brother, and sister).

Table 1. Billboard content by racial/ethnic population.

Billboard Content	Black/Hispanic		Mixed		Non-Hispanic White		Total	
	No.	Percent	No.	Percent	No.	Percent	No.	Percent
Addictive	168	76	123	62	24	42	315	66
Cigarettes	120	54	91	46	20	35	231	48
Alcohol	48	22	32	16	4	7	84	18
Nonaddictive	55	24	75	38	33	58	163	34
Total	223	100	198	100	57	100	478	100

Table 2. Visual content analysis of cigarette billboards.

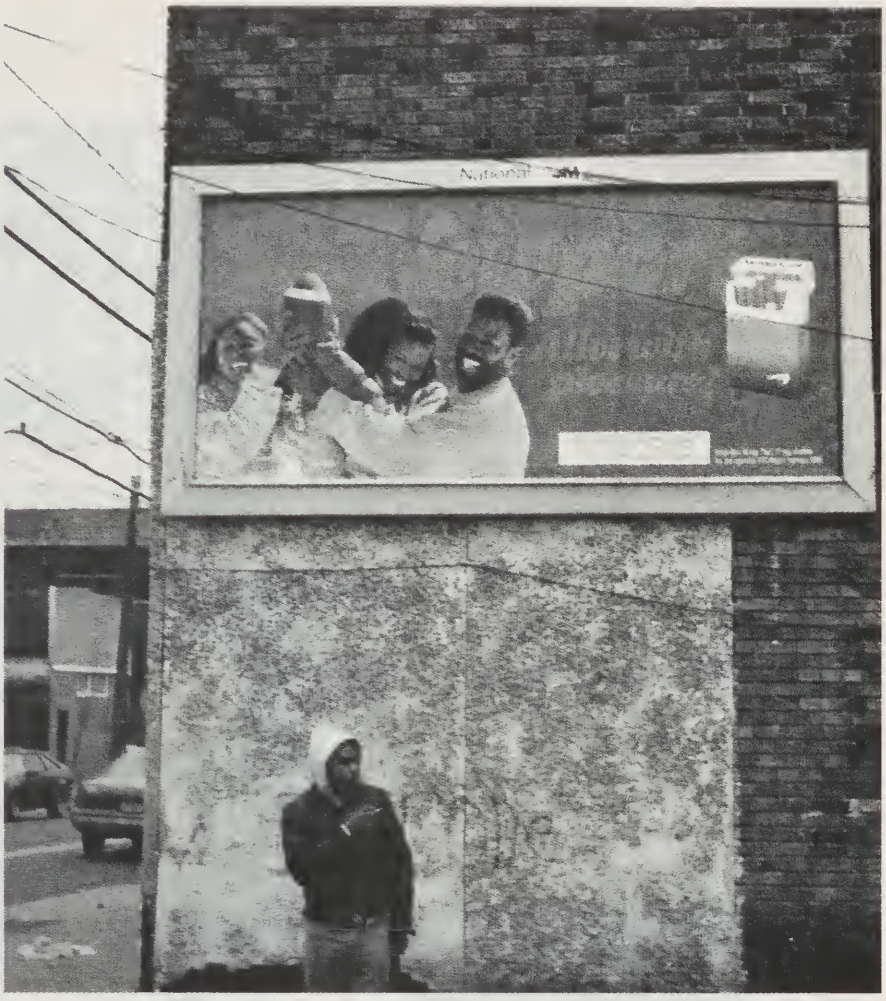
Billboard Content	Black/Hispanic		Mixed		Non-Hispanic White		Total	
	No.	Percent	No.	Percent	No.	Percent	No.	Percent
Targeted	93	78	65	71	11	55	169	73
Black/Hispanic	85	71	55	60	6	30	146	63
White (Non-Hispanic)	8	7	10	11	5	25	23	10
Neutral	27	22	26	29	9	45	62	27
Total	120	100	91	100	20	100	231	100

DISCUSSION

We found that billboards in black and Hispanic neighborhoods are much more likely to advertise cigarettes and alcohol than billboards in non-Hispanic, white neighborhoods. Furthermore, billboards in minority neighborhoods are much more likely to be targeted by using racial/ethnic models and Spanish language.

CONCLUSION

Recognizing the enormous damage caused by addictive behaviors, we recommend that blacks and Hispanics press local, state, and national governments to require the removal of addictive billboard advertisements. In particular, addictive billboard advertisements should not be permitted near schools, religious institutions, parks, playgrounds, hospitals, health centers, or government buildings. Billboards in these areas should be used for nonaddictive behaviors or removed. Furthermore, we urge minority communities and their supporters to call upon billboard advertisers to stop targeting their communities with advertisements that use images of youth, sex, and affluence to promote deadly behavioral risks. ■



Ms. Mitchell and Dr. Greenberg are affiliated with the Departments of Geography and Urban Studies and Community Health, Rutgers University. The paper was submitted in January 1991 and accepted in February 1991. Requests for reprints may be addressed to Dr. Greenberg, Rutgers University, Department of Urban Studies and Community Health, Lucy Stone Hall, New Brunswick, NJ 08903.

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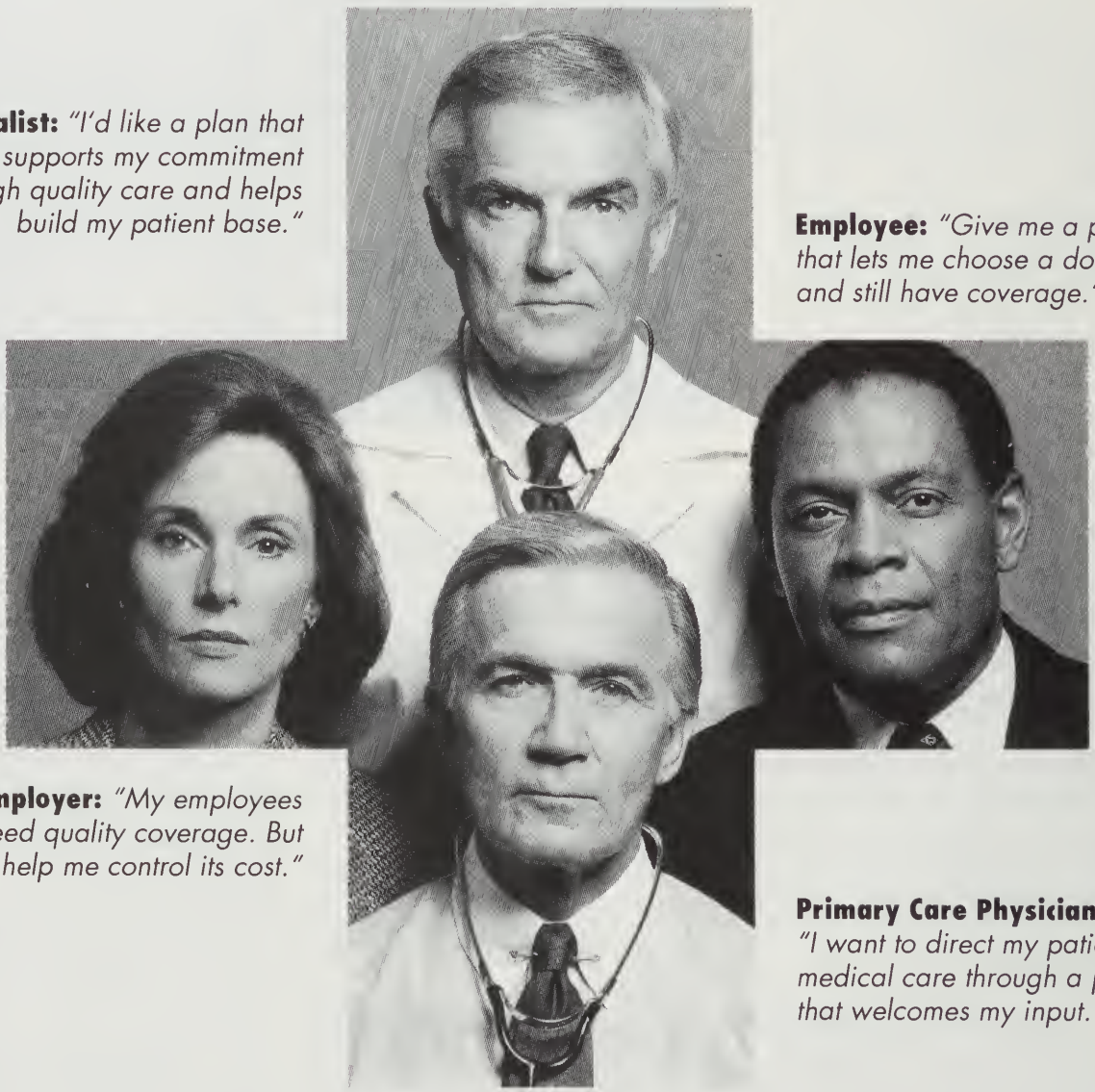
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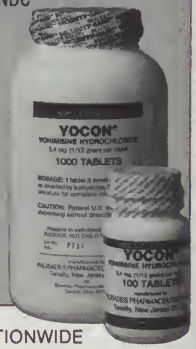
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Case Report: Cystic Duct Carcinoma

Leonard Galler, MD
Gary L. Feinberg, MD
Joseph J. Scarano, MD

The authors present the 26th reported case of cystic duct carcinoma. Cystic duct carcinoma is more prevalent in males and is associated with right upper quadrant abdominal pain. Survival can be extended with surgery.

Primary carcinoma of the cystic duct first was described by Weimershaus in 1941.[1] A literature search revealed 25 cases, the last case being reported in 1989, by Rivkind, Sherman, and Rabinovici (Table).[22] We present the 26th case of cystic duct carcinoma that fulfills the criteria established by Farrar.[4] As is typical of the other cases, our case of cystic duct carcinoma was discovered during a cholecystectomy for acute cholecystitis caused by cystic duct obstruction.

CASE REPORT

A 69-year-old white male was admitted after experiencing two severe episodes of right upper quadrant abdominal pain with radiation to his back and associated nausea without vomiting. On examination, the patient was afebrile with stable vital signs. His sclerae were not icteric and abdominal examination elicited right upper quadrant tenderness without rebound or guarding. Complete blood count and urinalysis were normal. Liver function tests demonstrated an elevated alkaline phosphatase: 181 U/L (normal, 26-102 U/L) and an elevated aspartate aminotransferase: 135 U/L (normal, 28 U/L). The bilirubin was 0.8 mg/dL (normal, 0.0-1.0 mg/dL) and the lactate dehydrogenase was 517 U/L (normal, 275-571 U/L). Serum amylase was 79 U/L (normal, 20-88 U/L). DISIDA scan was consistent with cystic duct obstruction. An ultrasound study of the gallbladder showed no stones, but question of a mucosal flap or polyp in the gallbladder was raised and there was a questionable echogenic mass in the right lobe of the liver.

Exploratory laparotomy was performed with the preoperative diagnosis of cholecystitis and a possible common duct stone. Cholecystitis was noted, plus a mass in the cystic duct. Cholecystectomy with complete excision of the mass, that was contained within the cystic duct, was performed. A frozen section revealed adenocarcinoma. An intraoperative cholangiogram was read as normal, demonstrating no other intraductal lesions or extrinsic compromise of the common duct. No liver mass was palpated at the time of surgery.

The final pathology showed an acute hemorrhagic cholecystitis and a moderately well-differentiated adenocarcinoma restricted to the cystic duct with tumor infiltrating the entire wall of the duct. There was no evidence of a malignant process extending into the fundus of the gallbladder. The patient had an unremarkable postoperative course. A computed tomography (CT) scan, subsequently obtained, showed multiple liver defects. It was felt that the patient was not a candidate for additional surgery and a course of radiation therapy was offered.

The patient deteriorated progressively over the next eight months. He developed liver failure, with coma, and subsequently expired.

DISCUSSION

For a malignant tumor to be considered a primary carcinoma of the cystic duct, certain criteria established by Farrar,[4] need to be met. These criteria mandate that the tumor must be confined to the cystic duct without the process arising from the gallbladder, common duct, or hepatic ducts. The incidence of primary cystic duct carcinoma is rare, with our case representing the 26th such case. It is estimated that cystic duct carcinoma comprises between 2.6 to 12.6 percent of all extrahepatic bile duct cancers.[23] More advanced cystic duct carcinomas cannot be differentiated from advanced neoplasms of the extrahepatic bile ducts, thus making the true incidence of the disease difficult to obtain.

The ages of patients previously reported have ranged from 38 years to 80 years, with an average age of 63 years (Table). The disease is more prevalent in males, with a 2.2:1, male:female ratio (Table). Clinical symptoms are those associated with cystic duct obstruction, including right upper quadrant abdominal pain noted in 80 percent of the reported cases. A palpable mass also has been noted in 38 percent of the cases. Jaundice is a less common finding occurring in 19 percent of the cases. Associated cholelithiasis has been noted in one-third of the cases reported. This incidence is significantly less than cholelithiasis associated with extrahepatic duct carcinoma, that occurs 68 percent of the time.[8,14]

The specific diagnosis of a cystic duct carcinoma seldom is made before laparotomy or autopsy. Preoperative testing often suggests cystic duct obstruction and a possible mass in the area of the cystic duct. CT scanning, ultrasound, and DISIDA often show a mass that must be differentiated further as an inflammatory or a neoplastic process.

The histopathology usually is a well-differentiated adenocarcino-

Table. Primary carcinoma of the cystic duct.

Source	Year	Age	Sex	Abdominal Pain	Palpable Mass	Tenderness	Result
1. Weimershaus[1]	1941	71	M	+	-	-	unknown
2. Oppenheimer[2]	1942	57	M	-	+	+	died 11 mos.
3. Ciocatto[3]	1945	50	F	+	-	-	unknown
4. Farrar[4]	1951	66	M	+	-	-	alive 6 mos.
5. Redmond and Majeranowski[5]	1954	73	M	+	-	-	autopsy case
6. Rabinovitch, et al.[6]	1960	54	F	+	+	+	died 1 day
7. Rabinovitch, et al.[6]	1960	60	F	+	+	-	unknown
8. Edelmann and Boutelier[7]	1963	58	M	+	+	-	alive 4 mos.
9. Pallette, et al.[8]	1963	68	M	+	-	-	alive 39 mos.
10. Parker[9]	1965	53	M	+	-	-	autopsy case
11. Hoerr and Hazard[10]	1966	70	M	+	-	-	alive 30 mos.
12. Smith, et al.[11]	1967	48	F	+	-	-	alive 52 mos.
13. Lombard, et al.[12]	1967	72	F	+	-	-	alive 2 mos.
14. Pack and Teng[13]	1968	61	M	-	+	-	alive 5 mos.
15. Phillips and Estrin[14]	1969	57	M	-	-	+	unknown
16. Vaittinen[15]	1972	38	M	+	-	-	alive 84 mos.
17. Vaittinen[15]	1972	70	M	+	-	-	alive 4 mos.
18. Vaittinen[15]	1972	75	F	+	-	-	autopsy case
19. Geoffrey and Maffioli[16]	1975	80	M	-	+	-	alive 4 mos.
20. Nishimura, et al.[17]	1975	52	M	+	-	-	alive 12 mos.
21. Manabe[18]	1978	55	F	+	+	-	alive 30 mos.
22. Walker[19]	1982	66	M	+	-	+	unknown
23. DeWaele, et al.[20]	1984	65	M	-	+	+	alive 18 mos.
24. Kogire, et al.[21]	1985	70	M	+	+	-	alive 12 mos.
25. Rivkind, et al.[22]	1989	80	F	+	+	-	died 7 mos.
26. Galler, Feinberg, et al.	1990	69	M	+	-	-	died 8 mos.
Averages		63	2.25:1	80%	38%	19%	

ma but two previous cases reported an undifferentiated carcinoma. Metastases are seen approximately one-third of the time. The treatment of a primary carcinoma of the cystic duct is cholecystectomy and cystic duct excision with extensive lymph node dissection; a Whipple resection is justified if all of the tumor can be removed. Reported studies stated aggressive surgery for cystic duct carcinoma gave rise to extended survivals, although average survival is 7 months. Long-term survivors of 30, 39, 52, and 84 months are noted (Table). This is significantly longer than the average survival of patients with gallbladder cancer or extrahepatic cancer, that is 5.8 and 3.2 to 11.4 months, respectively.

The role of adjuvant chemotherapy and radiation is debatable, without evidence of extended, disease-free intervals. ■

Drs. Galler, Feinberg, and Scarano are surgeons. The paper was submitted in November 1990 and accepted in January 1991. Requests for reprints may be addressed to Dr. Galler, 718 Shore Road, Somers Point, NJ 08244.

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Takayasu's Arteritis

Joel E. Krachman, DO
Dennis J. Cunniff, MD
Neil Kramer, MD
Elliot D. Rosenstein, MD

Two recent cases of Takayasu's arteritis illustrate the wide spectrum of disease presentation. The first patient demonstrated rapid development of ischemic manifestations; the second patient presented with septal panniculitis. Worldwide distribution of Takayasu's arteritis has increased.

Takayasu's arteritis is a chronic inflammatory arteriopathy of undetermined etiology involving the aortic arch and its branches. A disease of women in the second and third decades, the majority of case reports have originated in Japan and neighboring Asian countries. In recent years, the worldwide distribution of the condition in women has been appreciated, with an incidence in the United States comparable to polyarteritis nodosa.[1,2] Early in the course of illness, Takayasu's arteritis may present with systemic symptoms of fever, malaise, weight loss, myalgias, arthralgias, skin lesions, and anemia; these symptoms are typical of many inflammatory processes. As involvement of the large vessels progresses, more specific symptoms of vascular insufficiency, such as absence of vascular pulses, bruits, and upper extremity claudication, develop. The disease ultimately can progress to vascular stenosis and occlusion, leading to secondary hypertension, cerebrovascular involvement, cardiac manifestations, and premature death.[2,3]

We evaluated two patients with Takayasu's arteritis.

CASE REPORT 1

An 18-year-old white female experienced episodic dyspnea in May and June 1989, followed by persistent fatigue, a seven-pound weight loss, low-grade fevers, and night sweats. Evaluation of her complaints in September 1989 revealed anemia with a hemoglobin 9.0 gm/dl and erythrocyte sedimentation rate (ESR) of 85 mm/hr. Abdominal and pelvic computed tomography (CT) scans, total body gallium scintigraphy, small bowel series, and barium enema were normal. Bone marrow aspirate and biopsy showed normal marrow but absent iron stores. In November 1989, while on iron supplementation, the patient began experiencing postural dizziness and left upper extremity claudication. She became aware of buzzing pulsations over both carotid arteries, and noted dimming of vision with sharp movements of her head. She denied headache, diplopia, myalgia, or arthralgia. She went to a local emergency room following dizziness, and was referred for admission when examination revealed bilateral carotid bruits and an absent left brachial pulse.

Her physical examination noted: temperature, 98.8°F; pulse, 96 per minute; and respirations, 18 per minute. Blood pressure measured 110/70 mm Hg in the right arm and 130/90 mm Hg in both legs; blood pressure could not be obtained in the left arm. Fundoscopy showed no exudates, hemorrhage, or papilledema. Carotid bruits were present bilaterally as well as a left subclavian bruit. Chest, cardiac, abdominal, and neurological examinations were normal. Laboratory examination revealed WBC, 7,800/mm^3; hemoglobin 11.0 gm/dl; hematocrit, 33%; platelet count, 469,000/mm^3; ESR, 108 mm/hr; and C-reactive protein, 9.8 gm/dl: Blood chemistries, urinalysis, chest x-ray, and electrocardiogram were normal.

Thoracic and abdominal aortograms showed multiple areas of arterial narrowing in the carotid, subclavian, and thoraco-abdominal aorta distal to the aortic arch. Narrowing also was present in the common iliac artery, but there was sparing of the renal, internal, and external iliacs. There were no areas of arterial occlusion or aneurysmal dilatation (Figure 1).

The diagnosis was Takayasu's arteritis; the patient was treated with prednisone 60 mg per day for three months. The sedimentation rate fell to 7 mm/hr after two weeks of therapy and there was prompt resolution of her constitutional complaints. After three months of prednisone treatment, the blood pressure was 120/60 in



Figure 1. Aortic arch study showing extensive carotid and subclavian narrowing (case report 1).

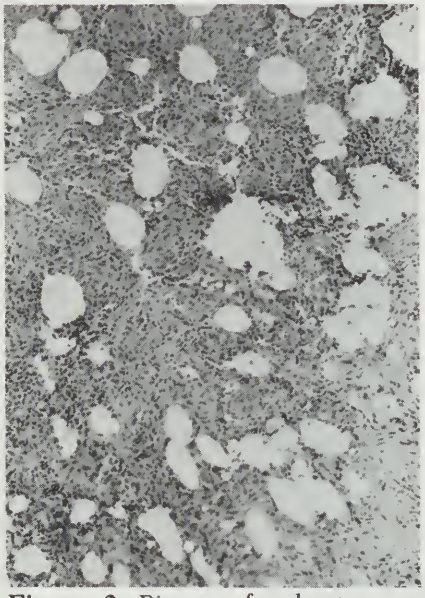


Figure 2. Biopsy of subcutaneous tissue revealing septal panniculitis with extensive fibrosis and marked lymphohistiocytic infiltrate (case report 2, original magnification x 40).

the right arm, 100/50 in the left arm, and 149/90 in both legs. Repeat aortogram showed slight improvement in the left subclavian artery and no progression or new areas of arterial narrowing. Therapy was converted to alternate day prednisone.

CASE REPORT 2

A 32-year-old black woman was seen in 1982 with a two-year history of intermittent fever associated with painful, erythematous subcutaneous nodules. Biopsy of one of these nodules revealed a chronic septal panniculitis with fibrosis (Figure 2). At that time, the patient received no treatment. She continued to spontaneously experience remitting episodes of fever and panniculitis that would last for two to three months. In April 1989, she first noted cramping and fatigue in both arms while performing minor tasks, such as haircombing. In October 1989 she was admitted to the hospital with a three-week history of bilateral pedal edema, dyspnea, and palpitations.

She had no history of rheumatic fever or previous heart disease. There was a history of treated tuberculosis, hyperthyroidism, and tobacco and cocaine use. She denied alcohol abuse.

Physical examination revealed a temperature of 99°F; pulse 120 per minute; and respirations of 26 per minute. Blood pressure was 80 mm Hg systolic in both upper extremities and 130 mm Hg systolic in both lower extremities. There was a 1 cm x 1 cm nasal septal perforation. The left lobe of the thyroid was enlarged with a 3 cm x 2 cm palpable nodule. Jugular venous distension, hepatojugular reflux, and bibasilar rales were noted. Laterally displaced maximal cardiac impulse, left parasternal heave, and a grade 2/6 murmur of mitral regurgitation were present. Hyperpigmented, indurated subcutaneous plaques and nodules were noted over the anterior tibial surface and 3+ pitting edema was evident.

Chest x-ray showed cardiomegaly and pulmonary venous congestion. Electrocardiogram showed a sinus tachycardia and evidence of left atrial enlargement. WBC was 11,100/mm^3; Hg was 12.0 g/dl; platelet count was 594,000 mm^3; and ESR was 102 mm/hr. Rapid plasma reagin and rheumatoid factor were negative. FANA was positive at 1:80 in a nucleolar pattern; anti-DNA and anti-Smith were absent; C-reactive protein was a 2.3 gm/dl. Lyme antibodies and viral cultures and antibodies to Coxsackie virus and echovirus were negative.

Doppler echocardiogram showed severe mitral regurgitation, mild to moderate tricuspid regurgitation, trace aortic insufficiency, mild pulmonic insufficiency, mild aortic sclerosis with good leaflet separation, an enlarged left atrium and ventricle, and left ventricular dysfunction. MUGA scan showed left ventricular ejection fracture of 24 percent and right ventricular ejection fraction of 23 percent. There was marked diffuse hypokinesis of both ventricles. Cardiac catheterization revealed severe global left ventricular hypokinesis, mild mitral regurgitation, and normal coronary arteries. Endomyocardial biopsy (Figure 3) showed mild interstitial fibrosis and mononuclear infiltrate.

Aortography showed bilateral occlusion of the subclavian arteries with the right subclavian filled via the thyrocervical trunk and the left subclavian filled via the left vertebral artery (Figure 4). There were diffuse ectatic changes in the distal thoracic aorta and right renal artery narrowing. The inferior mesenteric artery filled via the middle colic artery.

A diagnosis of Takayasu's arteritis was made and the patient was started on prednisone 60 mg daily. After receiving medication, she was lost to followup.

DISCUSSION

Takayasu's arteritis is a granulomatous arteritis with predilection for the aortic arch and its branches, leading to vascular stenosis and ischemic symptoms. In the United States, the annual incidence of Takayasu's arteritis is about 2.6 cases per million, comparable to polyarteritis nodosa or Wegener's granulomatosis, or about 1/10 the in-

cidence of a pathologically similar, but distinct, condition, temporal arteritis.[1] In approximately 70 percent of the patients, Takayasu's arteritis has an acute prepulseless phase. Patients usually experience fever, night sweats, generalized malaise, arthralgias, myalgias, and occasionally dermatologic manifestations. The majority of patients, however, are diagnosed in the ischemic phase that follows. An average of eight years intervenes between the two phases, with a range of months to decades.[1-5] Since there are no pathognomonic clinical or laboratory features, the diagnosis usually is made on a high index of clinical suspicion, with angiographic (vascular ectasia or occlusion, saccular or fusiform aneurysms) and, occasionally, histopathologic verification. Recently, diagnostic criteria have been proposed by Ishikawa based on clinical and anatomic features (Table).[6]

Our two patients represent different manifestations of the spectrum of disease. The first patient presented with a typical history of Takayasu's arteritis with early nonlocalizing symptoms, accompanied by laboratory abnormalities reflective of an inflammatory process. Six months later, she developed dizziness and left arm claudication, in association with bruits, upper extremity pulse and blood pressure asymmetry. The clinical suspicion of Takayasu's arteritis was high before the confirmatory aortogram was performed. Corticosteroid therapy resulted in rapid resolution of symptoms, laboratory abnormalities, and arrest of the vascular occlusive process.

On the other hand, the second patient presented with more atypical symptoms: the initial inflammatory manifestation was erythema nodosum. Characterized as a septal panniculitis, erythema nodosum often is seen as a hypersensitivity response to various infections, drug exposures, or as a manifestation of a systemic inflammatory disorder.[1,7] Erythema nodosum and several other dermatologic reactions including pyoderma gangrenosum, erythema induratum, tuberculoid eruption,[8] and cutaneous polyarteritis nodosa[9] have been reported as early manifestation of Takayasu's arteritis. In Hall's series, erythema nodosum was seen in 16 percent of patients.[1]

Because of patient noncompliance, the diagnosis of Takayasu's arteritis in the second patient was clinically unsuspected until eight years later when she presented in heart failure. At that time, the signs of vascular insufficiency were documented.

Although congestive heart failure is the most common mode of death in patients with Takayasu's arteritis, the cardiac failure usually is attributed to secondary hypertension or to valvular insufficiency, primarily aortic incompetence. Cardiomyopathy, however, is a less common manifestation, occurring in 4.5 percent of patients.[2,10] Prior reports have noted the presence of a mononuclear inflammatory cell infiltrate with myonecrosis and fibrosis similar to that reported in this patient.[11,12] On occasion, granulomatous involvement of the myocardium similar to that occurring in the vascular wall can be seen.[13] Viral and mycobacterial causes were considered in the differential diagnosis of the second patient, yet myocardial biopsy failed to reveal granulomata or viral inclusion bodies, and viral serologies for typical etiologic agents were negative. A less frequent cause of congestive heart failure, proximal coronary ostial narrowing resulting in ischemic cardiomyopathy, was excluded by the negative coronary angiogram.[14]

Active Takayasu's arteritis usually has been treated with corticosteroids. Typically, treatment is initiated with prednisone 1 mg/kg/day that is slowly tapered after four weeks if therapeutic response, as measured by clinical symptoms and serial ESR, is achieved. Studies have suggested that corticosteroid therapy will prevent the long-term vascular complications and improve survival.[5] If prednisone is ineffective, cytotoxic agents such as cyclophosphamide,[5,12] and, more recently, methotrexate, may be added.[15] Balloon angioplasty or surgical revascularization are in-

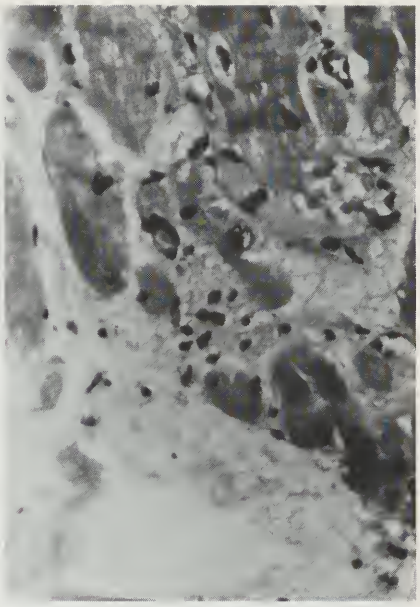


Figure 3. Endomyocardial biopsy. There is mild interstitial fibrosis and myonecrosis with monocytic infiltrate (case report 2, original magnification x 100).

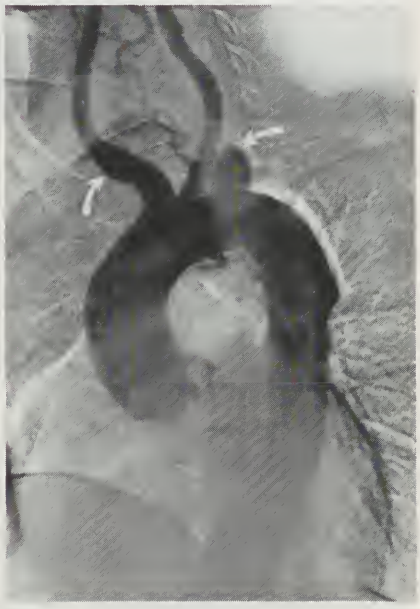


Figure 4. Aortic arch study. Occlusion of right subclavian artery and of left subclavian artery at its origin from the innominate (case report 2).

Table. Criteria for diagnosis of Takayasu's disease.

Obligatory criterion

Age ≤40 years at diagnosis or onset

Major criteria

Left subclavian artery lesion with midportion narrowing or obstruction
Right subclavian artery lesion with midportion narrowing or obstruction

Minor criteria

ESR (Westergren) ≥20 mm/hr
Carotid artery tenderness
Hypertension (≥140/90 mm Hg brachial or 160/90 mm Hg popliteal)
Aortic regurgitation or annuloaortic ectasia
Pulmonary artery involvement with occlusion, stenosis, aneurysm, or luminal irregularity
Left midcommon carotid artery lesion with stenosis or occlusion
Distal brachiocephalic trunk lesion with stenosis or occlusion
Descending thoracic aorta lesion with narrowing, dilatation, aneurysm, or luminal irregularity
Abdominal aorta lesion with narrowing, dilatation, aneurysm or luminal irregularity

Diagnosis requires obligatory criterion and either two major criteria, one major and two minor criteria, or four minor criteria.[6]

dicated for severe ischemic compromise, renal artery stenosis, valvular insufficiency, and aortic aneurysm formation.[1,2,5,16] Since hypertension is a major complication of the condition and contributes to the development of congestive heart failure, adequate control of blood pressure is of primary importance.

A five-year overall survival rate of 83 percent has been noted in patients with Takayasu's arteritis. A ten-year survival rate of 58 percent in patients with severe disease was estimated by Ishikawa.[5,17] On the basis of a retrospective study, Fraga claimed a significantly higher mortality rate with only 25 percent survival at two years from diagnosis.[18] Shelhamer conducted a prospective study and found 14 of 18 patients responding to medical therapy in a 48-month trial.[5] However, the accurate determination of the life expectancy of these patients while on adequate therapy cannot be made in the absence of studies with longer periods of followup. ■

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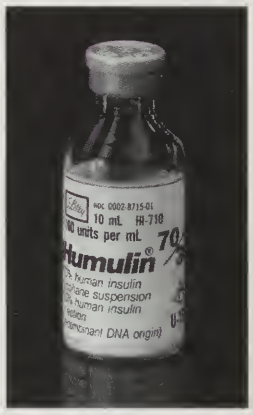


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Mucinous Adenocarcinoma of the Pancreas

Brij M. Mitruka, PhD, MD
Madhusudan G. Rao, MD
Anis F. Rangwala, MD

The authors report a patient with mucinous adenocarcinoma of the pancreas with multiple cystic spaces, lined with malignant columnar cells and papillary formation; adjacent pancreatic tissue shows chronic pancreatitis. This is an unusual case report.

Mucinous cystic neoplasms of the pancreas are uncommon but well recognized.[1-11] The literature reviews on mucinous adenocarcinoma show the distribution and sites of origin are similar to those of duct carcinoma and have an association with long histories of chronic pancreatitis, alcoholism, and diabetes.[1-11] Mucinous adenocarcinoma also has been reported to cause biliary obstruction,[5] and renal tubular obstruction by mucoprotein[6] excreted from the pancreatic cancer. The case presented in this report is unusual in that mucinous adenocarcinoma is seen along with typical solid ductal adenocarcinoma and chronic pancreatitis.

CASE REPORT

A 76-year-old man presented with intractable nausea and vomiting. He recently was discharged: postcerebrovascular accident with residual right hemiparesis. It was believed that his stroke was secondary to atrial fibrillation. In addition, the patient had a history of diabetes mellitus and was status post-*Clostridium difficile* colitis infection. He also had a longstanding history of hypertension. The patient was receiving ongoing rehabilitative therapy at home when it was noted that he had continued nausea and vomiting. A computed tomography (CT) scan of the abdomen revealed a polycystic mass replacing the entire body and tail of the pancreas. The patient underwent near total pancreatectomy with splenectomy; a laparotomy showed the liver to be normal in size. The stomach was within normal limits. The patient had a Billroth II previously. The kidneys were polycystic. The pancreas was multicystic from the body to the tail. The patient was discharged from the hospital on postoperative day 12.

The patient was seen by his internist for hemorrhoids and is doing well five months after the partial pancreatectomy.

PATHOLOGIC FINDINGS

The specimen received was a portion of the body and tail of the pancreas attached to the spleen. Grossly, there were a number of cystic structures ranging from 0.5 to 1.5 cm in greatest diameter, covering the entire surface of the pancreas (Figure 1). Cysts were filled with a thick and gelatinous mucinous material. Frozen section diagnosis was cystic mucinous tumor. Multiple sections from cystic as well as noncystic

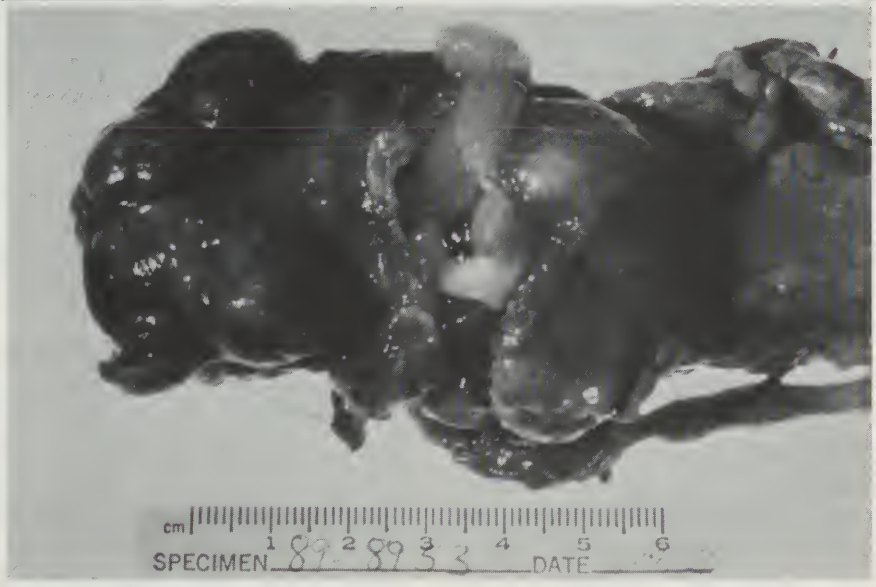


Figure 1. Multicystic mass in the body and tail of the pancreas.

areas of the pancreas showed mucinous adenocarcinoma of the pancreas. The tumor was a typical colloid carcinoma with multiple cystic spaces, most of them not lined by epithelial cells (Figure 2). However, an epithelial lining was identified that had malignant characteristics, tall columnar cells with hyperchromatic nucleus, stratification, multi-layering, presence of mitotic figures, and cribriforming together with papillary formation. Floating tumor cells or epithelial fragments (Figure 3) were found in many of these cysts. Adjacent pancreatic tissues showed atrophic changes together with chronic pancreatitis and at places showing well-differentiated ductal adenocarcinoma (Figure 4). No distinct perineural invasion was identified. There was no evidence of metastases in eight lymph nodes examined. The spleen showed reactive changes.

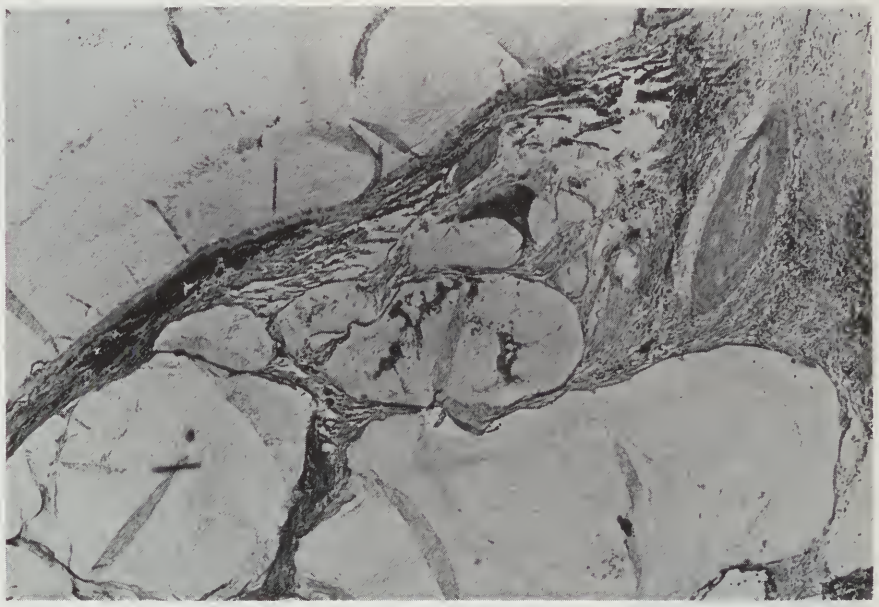


Figure 2. Low-power magnification showing multicystic tumor in the body of the pancreas (H & E x 5).

COMMENT

Mucin-producing adenocarcinomas of the pancreas are rare and comprise less than 2 percent of all pancreatic carcinomas.[1] These mucin-producing adenocarcinomas are further categorized into mucinous cystadenocarcinomas and mucinous adenocarcinomas. Of the two, mucinous cystadenocarcinomas are more common. These occur typically in women, with peak incidence around the fifth and sixth decades. As these tumors are located in the body and tail of the pancreas, jaundice is a less common presenting symptom. Abdominal pain, masses, or weight loss are typical presenting symptoms.

Mucinous adenocarcinomas other than cystadenocarcinomas have been reported.[1,4-6] The difference is whether the cyst wall is completely lined with mucin-producing columnar epithelium with frond formation (cystadenocarcinoma) or with only large cystic spaces filled with mucus and compressed collagen septa (mucinous adenocarcinomas). Almost always, the mucin-producing columnar epithelium is present in focal areas and partially lines the cystic spaces (mucinous adenocarcinoma). Floating in mucin are clumps or strands of malignant cells. At times, papillary fronds also can be found.

It is important to distinguish between mucinous adenocarcinoma and cystadenocarcinoma because of prognostic significance, as the natural course of cystadenocarcinoma is indolent compared to mucinous adenocarcinomas.

Compagno and Oertel[13] found 20 of 41 patients with mucinous cystadenocarcinoma alive and well with an average followup of 6.7 years, as compared to mucinous adenocarcinoma where median survival period of the 5 patients was 11 months.[4] Thus, mucinous adenocarcinomas have a rapid downhill course as compared with mucinous cystadenocarcinomas.

These tumors also have to be distinguished from papillary and cystic tumors of the pancreas.[12-14] These neoplasms occur predominantly in girls and young women. Until recently, these tumors were misclassified as nonfunctioning islet cell tumor or carcinoma, acinar cell carcinoma, or papillary cystadenocarcinoma according to microscopic findings and frequently have been managed with aggressive surgery. The tumors are well encapsulated and the cut surface shows solid and hemorrhagic necrotic areas.

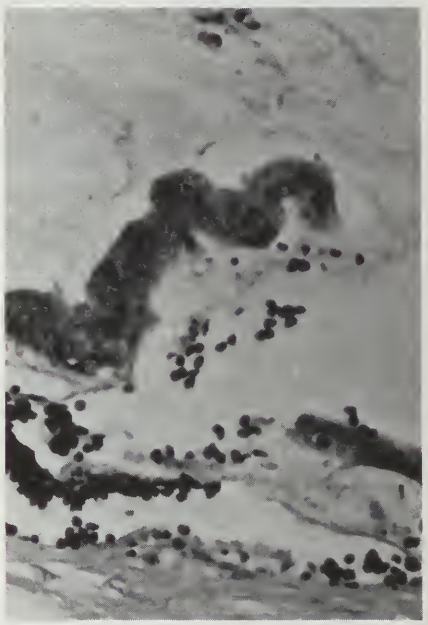


Figure 3. Floating tumor cells lie within lakes of epithelium mucin (H & E x 200).

The present case also had typical solid ductal adenocarcinoma along with mucinous adenocarcinoma. The solid component comprised 20 percent of the total tumor mass. This indicates a close relationship between solid and

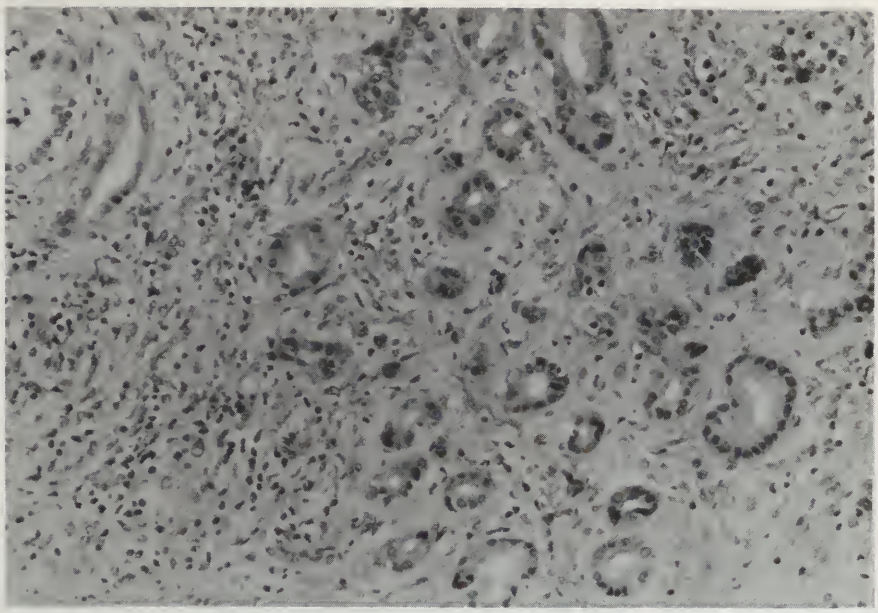


Figure 4. Well-differentiated ductal adenocarcinoma of the pancreas (H & E x 200).

mucinous adenocarcinoma. No such association is found between mucinous cystadenocarcinomas and solid ductal carcinoma. Solid ductal carcinoma of the body and tail carries a worse prognosis compared to mucinous adenocarcinoma (1 percent survival at the end of one year).[15] ■

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John McKelway: A Man of True Vision

Nancy M. Propsner, BA

A rare man, John McKelway, MD, is the founding father of the Hunterdon and Mercer County Medical Societies. Dr. McKelway (1788-1877) was a progressive physician and businessman. He is remembered for being a rigid observer of medical ethics.

John McKelway was "a rare man . . . courteous and polished in the extreme in manner, of iron will and determination, ignoring difficulty, danger, or fatigue in whatever he undertook to accomplish."[1] This was the spirit that the founding father of the Mercer County Medical Society and of the Hunterdon County Medical Society needed to guide the beginnings of these societies.

EARLY YEARS

Dr. John McKelway, the son of Alexander McKelway, was born in Glasgow, Scotland, on January 7, 1788. He attended the University of Glasgow for two sessions from 1813 to 1815, first studying anatomy and surgery, and then chemistry and jurisprudence.[2] Shortly after completing his studies, Dr. McKelway immigrated to the United States, initially locating in Lancaster, Pennsylvania, for one year, then moving to Trenton. A few years later, his wife, Isabella Margaret McGregor (1786-1866), whom he had married in Scotland, joined her husband in America.[1,3,4,6]

John and Isabella had seven children: Alexander Jeffery (1813-1887), a surgeon in the Union Army during the Civil War; Elizabeth Mary, died in infancy in 1816; John (1818-1852), a United States consul at Curacoa; Elizabeth Imlay (1820-1827), buried at the Trenton Presbyterian Church cemetery; George Washington (1822-1880), buried at Mercer Cemetery, Trenton; Margaret Sarah (1823-1857), born and died in Trenton; and Louise Fanny (1827-1861).[3-5]

LOCAL DOCTOR

A Trenton physician for over 50 years, Dr. McKelway was recognized as a leading practitioner during his time, known for his "rigid observance"[6] of the ethics of the medical profession. The June 1916 issue of *The Journal of*



Figure. Dr. McKelway, the founding father of the Hunterdon and Mercer County Medical Societies.

the Medical Society of New Jersey records an incident that exemplifies Dr. McKelway's strong nature as a doctor. During the digging of the Raritan Canal in 1835, there was an epidemic of cholera in Trenton. Being the senior practitioner of six Trenton doctors, he said to them: "We have a very hard problem, the afflicted will die so we must act from the basis of 'kill or cure' and my decision is to visit every sick room and dose each patient with 20 grains of calomel." The treatment was successful; the epidemic was controlled with a high survival rate.[7]

Another portrait of Dr. McKelway is seen in a short sketch by Dr. Cornelius Shepperd. At the age of 73, a fractured thigh bone left Dr. McKelway in splints for a few weeks. Feeling that repair was impossible, Dr. McKelway continued to practice medicine for ten years using crutches. A special carriage was designed for his use, making easy entry and exit of the carriage with crutches.[1]

Dr. McKelway was appointed by President Tyler to be postmaster of Trenton (1842-1843). With other physicians, Dr. McKelway was a member of the first Trenton board of health, and was a prominent member of the Presbyterian Church of Trenton.[1,4,6]

HUNTERDON COUNTY

In May 1821, Dr. McKelway and 12 other physicians (Drs. Nicholas Belleville, James T. Clark, Joseph Phillips, William Johnson, Henry B. Poole, William P. Clark, John Bowne, William Geary, Henry S. Harris, John A. Hendry, Henry H. Schenck, and Edmund Porter) were permitted by the Medical Society of New Jersey to organize a medical society for Hunterdon County. An organizational meeting was held in Flemington on June 12, 1821. At this meeting, Dr. McKelway was one of the physicians appointed to draft the constitution and bylaws.[8]

"The History of the District Medical Society for the County of Hunterdon," recalls Dr. McKelway as being "a very active member during the first years of its existence." He served as president, elected in May 1826; on the Board of Censors for the years 1822 to 1824 and 1826; and as a delegate to the Medical Society of New Jersey. On April 18, 1871, Dr. McKelway was elected an honorary member of the Hunterdon County Medical Society, having become a resident of Mercer County in 1838, when it was formed from parts of other counties, including Hunterdon County.[8]

MERCER COUNTY

Along with Drs. John H. Phillips, Henry P. Welling, James B. Coleman, and Francis A. Ewing, Dr. McKelway was one of the founding fathers of the Mercer County Medical Society, permission having been granted by the Medical Society of New Jersey on May 9, 1848. An organizational meeting was held at Samuel Kay's house in Trenton, on May 23, 1848, at 10 A.M. Dr. McKelway was elected president and was appointed as a delegate to the State Society.[9]

Dr. McKelway presided as president for one year until April 1849. During his term, five meetings, including the organizational meeting, were held: May 23, 1848, July 25, 1848, October 24, 1848, January 23, 1849, and April 24, 1849. At the January 1849 meeting, Dr. McKelway was appointed censor to the Board of Censors for surgery and practice of medicine, to examine members for membership.[9]

After his term as president, Dr. McKelway continued to serve the Mercer County Medical Society in other capacities: as vice-president from April 1854 to April 1855; and as a delegate, along with several others, to the January 23, 1855, Annual Meeting of the Medical Society of New Jersey in Trenton. He also served as a delegate on several occasions to the national medical association and to the State Society; as a delegate to the national medical association, appointed in April 1849, April 1856, and April 1857; and as a delegate to the State Society, appointed in January 1856 and April 1857.[9]

BUSINESS ENDEAVORS

Aside from being recognized as a leading medical man of Trenton, Dr. McKelway was regarded as "a progressive citizen."[6] He accumulated wealth from various business ventures: He was a member of the first board of directors of Mechanics and Manufacturers Bank, Trenton, in 1834. Dr. McKelway was one of several incorporators of the Trenton and South Trenton Aqueduct Company, in 1848. He invested in Trenton real estate: purchasing on April 2, 1845, the original State House that was remodeled and opened as the State Street House and later as the Sterling Hotel; records note that in 1855, the first school term of the State Normal School of Trenton was temporarily held in a building owned by Dr. McKelway on the corner of Hanover and Stockton Streets in Trenton.[1,3]

LAST YEARS

A fracture of his hip from a slip on icy pavement forced Dr. McKelway to retire from the active practice of medicine. Dr. McKelway died in Trenton on April 23, 1877, aged 89, after being confined to his house for six years. He is buried at Mercer Cemetery in Trenton.[6,10] ■

References are available upon request.

Ms. Propsner is an editorial assistant for *NEW JERSEY MEDICINE.*

Physician Office Laboratory Quality Assurance

Kathleen L. Voldish, CLA

The physician office laboratory (POL) must establish a quality assurance (QA) program. QA is the process of assuring that all testing services have been performed. Documentation of an office QA protocol is a requirement of the upcoming federal regulations (CLIA-88).

Quality assurance (QA) is the process of assuring that all testing services involved in the delivery of patient care have been performed in an appropriate manner. In an office setting, the physician is responsible for the accuracy of the information his laboratory produces. Patient management decisions will be made based on the interpretation of the test results. QA is important in any laboratory setting and it possibly is more important in the POL, where the people performing the tests often have minimal technical training.

The following information will help the POL achieve the highest level of testing precision and accuracy, and validate test results. The eight areas of QA outlined are essential for a complete POL program.

CLERICAL PROCEDURES

1. Request forms must be written legibly and correctly.

2. Test tubes must be labeled properly. If the name on the request form does not match the name on the specimen, the specimen should be discarded and another specimen drawn.

3. Test orders for patients must be written in a daily log and should include the name of the patient, the date and time collected, tests requested, and physician ordering the test (in case of group practice). The following information also is useful: whether patient was fasting; time last dosage of medication was taken (in drug levels); source of specimen (in cases of bacteriologic studies); if studies were performed inhouse or sent to a reference laboratory; and when tests were performed.

4. Reporting of test results must be legible and accurately transposed. Verbal reporting of results should be avoided. Copies of all tests performed inhouse should be kept in the laboratory.

PATIENT PREPARATION

1. Accurate patient identification is essential. The patient should state his name; it should correspond to the name on test request form.

2. A patient should be questioned before the specimen is collected to make sure the patient has prepared for the test.

3. Written procedures for how to fast and to properly collect specimens other than blood (urine, bacteriologic, and stool) must be available to patients prior to testing.

SPECIMEN PROCESSING

1. Information on venipuncture technique and micro-collection technique should be in the procedure manual.

2. Care must be taken to select the appropriate tubes (proper additive) and needles for each test.

3. Specimens must be sufficient for accurate results. Complete blood counts and coagulation specimens should not be processed if insufficient.

4. Anticoagulated specimens must be properly mixed (60 inversions) and checked for any clots prior to testing.

5. Tests that are affected by hemolysis or lipemic serum should be listed in the procedure manual. If these conditions exist, the specimen should be discarded or the condition must be noted.

6. Centrifuges should be properly maintained. The timer should be periodically checked and the inside should be cleaned with disinfectant. Specimens should be spun for the proper amount of time as indicated in the test manual. Pipettes should be clearly marked and pipettes with broken tips should be discarded. Bulbs must be used to draw up specimens. Mouth pipetting is not allowed. Refrigerators and incubators must have daily temperature checks. Acceptable range for refrigerators is 4° to 8°C. Acceptable temperature for incubator is 37°C. These

checks should be recorded. If there is an extended power outage, specimens, reagents, and controls must be considered questionable and discarded.

7. Specimens that are not processed immediately must be stored as directed in the procedure manual for test requested.

PERSONNEL

Good and bad laboratories use the same equipment, the same reagents, and the same supplies. The major difference between good and poor results is the personnel who care for the equipment and perform the tests:

1. The physician director is solely responsible for seeing that the person performing the test has been properly trained.

2. The physician must provide the employee with continuing education seminars or self-study programs.

3. Personnel training and educational background must be documented and kept in the employee's file.

4. Personnel performance will be periodically evaluated by the director.

5. The physician needs to provide safety training to all personnel and document the training in the employee's file.

PROCEDURE MANUAL

The procedure manual will contain complete and specific information and instructions for every test performed in the POL. Each procedure will have the following information: name of test; background or principle of test; type of specimen, handling of specimen, and storage of specimen; materials needed (controls, standards, reagents, test tubes, and equipment); how to prepare or reconstitute standards, controls, and reagents; test procedures (step-by-step instructions, manufacturer manuals, or inserts with written notes); instructions on how to record results of test and controls; where results go after recording; interpretation of results—normal and panic values of test; and reference aids.

EQUIPMENT

1. All maintenance (including calibrations) should be recorded and kept in a notebook or log for the life of the instrument.

2. Maintenance schedules provided in the manuals of analyzers should be followed as closely as possible.

3. Diluters and automatic pipettes should be checked weekly for correct dispensing.

4. Centrifuge timers must be checked monthly with a stopwatch.

5. Refrigerators and incubators must have daily temperature checks.

6. Stain solutions should be changed monthly.

7. Microscopes should be covered when not in use to protect from dust. Outer lenses should be cleaned with lens paper or dust-free cloth. A small amount of alcohol or solvent can be used to clean the oil objective lens. The manufacturer should clean and adjust inside objectives—once a year.

QUALITY CONTROL

Quality control (QC) checks the precision of tests to see if the test system is functioning properly. QC defines the limits of acceptable performance:

1. Normal and abnormal (if available) controls must be performed for all tests. Lot numbers, expiration date, date opened, control range, mean, and control results must be recorded. Controls outside limits can be the result of human error, material error, or instrument error.

2. If the controls are "out of control" the following steps need to be followed to correct the problem: check controls and reagent for contamination or outdating; reanalyze the same control—if it is still out of limits; use fresh vials of controls; calibrate the instrument and run controls again; call the manufacturer for help or service and send the specimen out to reference laboratory for testing; and record all corrective action and maintenance on instrument.

3. Process controls included in pregnancy, occult blood, and serologic testing must be used according to manufacturer instructions and results must be recorded to validate results.

4. Microbiologic media plates need to be checked for hydration and sterility and stock organisms should be used to check media.

5. Monthly standard deviations must be calculated (by instrument or manually) and reviewed by the laboratory manager and the physician director. If the manufacturer offers a commercial QC program, it should be utilized.

6. Compare results with the controls and standards and to the reference or normal values of test in the procedure manual. Panic levels will be acted upon immediately.

PROFICIENCY TESTING

Proficiency testing (PT) is the most powerful tool for identifying problems in the laboratory and checking the laboratory's accuracy:

1. The PT program enrollment must cover all tests performed in the POL.

2. PT samples need to be prepared and reconstituted according to manufacturer's instruction.

3. Run PT samples as carefully as you check a patient. Never send samples to a reference laboratory.

4. Record results on the PT form. Photocopy the results for your records.

5. Review PT results carefully when you receive them.

6. Take corrective action and record the action if there is a problem. ■

Ms. Voldish is a registered technologist and laboratory manager, and POL consultant. Requests for information can be addressed to Ms. Voldish, 1150 Concord Drive, Haddonfield, NJ 08033.

DOCTORS' NOTEBOOK

TRUSTEES' MINUTES

A regular meeting of the Board of Trustees was held on March 17, 1991, at the executive offices in Lawrenceville. Minutes are on file with the secretary of your county society. A summary of significant actions follows:

President's Report . . . Stressed the importance of joining the AMA and noted the formation of the Ad Hoc Committee on Membership.

Exec. Director's Report . . .

1. MSNJ Membership . . . Received for information a copy of the membership report as of February 28, 1991.

2. Financial Statements . . . Reviewed and approved MSNJ's financial statements for the period ending January 31, 1991.

3. Medicare Global Surgical Fee Regulations . . . Noted that MSNJ's comments regarding the Medicare Global Surgery Fee regulation are consistent with those of the American College of Surgeons and the AMA. Also, noted that the Council on Medical Services is an appropriate forum for concerns about health care for the elderly.

4. Legislation . . . Noted the following: the mandatory assignment bill (A-4367) is still being considered by the Assembly Appropriations Committee; several lobbying interests opposing various sections of S-3251 (Health Care Reform) are meeting to discuss the possibility of engaging in a united effort to challenge the legislation; and S-2607 (Clear and Convincing Evidence in Licensure Action) now is in the Assembly. Also, charged Board members either directly or through another to request the hospital medical staff in their area to contribute to MEDAC by June.

5. Medical Waste Registration . . . Noted that the Department of Environmental Protection has the authority to levy fines up to $50,000 for noncompliance with the medical waste management law; MSNJ is preparing a mailing to be sent to all members of MSNJ and all insureds of MIIENJ advising them about the law and providing them the opportunity to comply with the law.

Specialty Reports . . . Received reports from the University of Medicine and Dentistry of New Jersey and from the New Jersey Hospital Association.

Committee on Medical Education . . . Adopted the following resolutions:

Resolved, that steps be taken to establish a working arrangement between the two organizations (MSNJ and the Academy of Medicine of New Jersey) in all matters relating to medical education:

These steps will include:

1. The president of MSNJ will be an ex-officio member of the Board of Trustees of the Academy of Medicine of New Jersey (AMNJ).
2. MSNJ shall designate two additional members to serve, ex-officio, as members of the Board of Trustees of AMNJ.
3. A member of the Committee on Medical Education of the Medical Society of MSNJ shall be a member of the Education Committee of AMNJ.
4. The executive director of AMNJ shall be a consultant to the Committee on Medical Education of MSNJ. He or his designee will give a regular report at each meeting of the MSNJ's Committee on Medical Education.
5. Efforts will be made to coordinate all educational activities of both organizations. This will include announcements in all relevant publications of both organizations.

Committee on Membership Services . . . Approved the following recommendations:

That the Board of Trustees approve the request of the E. & W. Blanksteen Agency to conduct a survey of the membership.

That the Private Pension Plan offered by Donald F. Smith & Associates be endorsed and offered as an additional service to the Society's members.

Physicians' Health Program . . . Approved the following recommendation:

That the Board of Trustees of MSNJ approve the Physicians' Health Program budget proposal for the 1991-1992 fiscal year.

Also, voted to forward the following recommendations to the Council on Legislation for action:

That the Medical Society of New Jersey oppose the Assembly Committee Substitute for Assembly bills numbered 4282, 4259, 4262, 4272, 4273, 4274, 4283, and Senate bill number 3131, because these bills would deprive the citizens of New Jersey of the benefits of legally mandated coverage, such as alcohol and drug abuse treatment.

That the lobbyist for MSNJ be instructed to act for the defeat of the proposed legislation.

And, voted to support the Coalition for Comprehensive Health Care (an organization comprised of mental health agencies and societies within New Jersey, working to obtain a uniform benefits package for qualitative and cost-effective treatment of alcoholism, drug abuse, and mental health disorders) and approved the contribution of $500 to be used for a study of the best way to achieve the Coalition's goals.

Unfinished Business . . . Voted to reaffirm the position of

the Council on Legislation stating disapproval (on the grounds that they constitute infringement on the practice of medicine; the services described in the bills are being performed as a standard of good medical practice) for S-3053 (Blood Transfusion) and A-4082. Also, agreed to support legislation efforts to strike the provision of the Budget Reconciliation Act that alters the reimbursement method for physicians who use ECGs.

New Business . . . Noted that a travel reimbursement increase will be reviewed; deferred action of a letter from Dr. Ian Samson regarding the proposal to dissolve the Senior Citizen's Task Force and restructure the Committee on Senior Citizens until the next meeting when Dr. Samson can present his views; and, adopted the following resolution:

Resolved, that MSNJ believes that laser surgery should be performed only by individuals licensed to practice medicine and surgery, and/or by those categories of practitioners currently licensed by the state to perform surgical services; and be it further

Resolved, that MSNJ oppose any bills that would extend the use of laser surgery beyond the classes listed above.

Also, sent a congratulatory letter to Dr. Rineberg on his election as second vice-president of the American Academy of Orthopaedic Surgeons. □

UMDNJ NOTES

Study tests AZT to prevent maternal-fetal AIDS transmission. A new study to determine if the drug AZT can prevent the transmission of the AIDS virus from the infected mother to her fetus is being initiated at the University of Medicine and Dentistry of New Jersey (UMDNJ), Newark. The clinical trial, which also will assess the safety and tolerance of the drug in pregnant women and newborns, is sponsored by the National Institute for Allergy and Infectious Diseases (NIAID) of the National Institutes of Health (NIH). UMDNJ, one of three pilot sites selected for the study, is one of the NIH's nationwide AIDS Clinical Trials Units and has had significant experience in treating women and children with AIDS. The study is being led by Dr. Edward Conner, associate professor of pediatrics and director of the AIDS Clinical Trials Unit at UMDNJ-New Jersey Medical School.

New vasectomy requires no scalpel. A new type of vasectomy that involves no cutting with a scalpel is being performed at UMDNJ-Robert Wood Johnson Medical School, New Brunswick. Dr. Kenneth B. Cummings, professor of surgery and chief of urology at the medical school, is 1 of fewer than 100 surgeons in the United States who can perform the sterilization technique, developed in China.

The standard vasectomy requires at least one incision into the scrotum to allow the physician to reach and tie or cauterize the two vas deferens—tubes that transport sperm. The new no-scalpel vasectomy is far less invasive, employing one tiny puncture that is made in the skin under local anesthesia.

The new procedure is almost bloodless, needs no sutures and requires a third less operating time. Men report less discomfort during and after the procedure than with the traditional method, and there is less swelling.

The new method also appears to reduce the risk of hematoma—blood pooling under the skin that can cause soreness. A study of 121,527 men who underwent the new procedure in China reported that only 97 men, or .08 percent, developed hematomas, compared with 2 percent of 65,155 men who underwent traditional vasectomy in the United States.

Students in HOT Program get first-hand look at health careers. Seventh graders from every New Brunswick public and parochial school participated in a day-long Health Occupations of Tomorrow (HOT) Program at UMDNJ-Robert Wood Johnson Medical School, New Brunswick. Nearly 200 youngsters toured the clinical campus and took part in hands-on demonstrations of equipment used by health care professionals, including respiratory therapy apparatus, radiology equipment, and a fully-equipped emergency medical services ambulance. Health care specialists discussed with the students the challenges and rewards of their careers. □
Stanley S. Bergen, Jr, MD

MSNJ AUXILIARY

Doctors' Day at the Legislature. Doctors in white coats and Auxiliary members sporting badges with violet ribbons descended on the State House in Trenton on March 11, 1991. They came from every part of the state in a united effort to oppose the mandatory Medicare assignment bill, A-4367, introduced by Assemblywoman Stephanie Bush. Many of those attending used the opportunity to visit county legislators and to voice their personal objections to the bill. This trip was the first in a series of activities undertaken by the Auxiliary to celebrate Doctors' Day, March 30. Although the Auxiliary has been honoring doctors on that day for the last 58 years, this year's observance has special meaning because Congress and the President have authorized March 30, 1991, as the first National Doctors' Day.

White House Proclamation. In

signing the proclamation, President Bush declared that March 30 should be a day recognizing physicians for their "invaluable contributions" to the welfare of the nation and honoring those "who carry on the quiet work of healing each day in communities throughout the United States—indeed throughout the world." The President added, "Common to the experience of each of them, from the specialist in research to the general practitioner, are hard work, stress, and sacrifice. All those Americans who serve as licensed physicians have engaged in years of study and training, often at great financial cost. Most endure long and unpredictable hours, and many must cope with the conflicting demands of work and family life."

Doctors' Day Started in Georgia. It was for many of these same reasons that, in 1933, Eudora B. Almond of the Barrow County, Georgia, Medical Society Auxiliary suggested that her Auxiliary set aside a special day to pay tribute to the hard work and dedication of local physicians. She selected March 30 because it was on that day in 1842, that a Georgia physician, Crawford W. Long, MD, introduced ether anesthesia into surgery.



Figure. Auxiliary members and MSNJ physicians gather in Trenton to oppose the mandatory Medicare bill.

On the first Doctors' Day in 1933, Auxiliary members mailed cards to doctors and their spouses in Winder, Georgia, and placed flowers on graves of deceased physicians, including Dr. Long. The idea grew and by 1935, Doctors' Day had become a special project of the Auxiliary to the Southern Medical Association.

Today, Auxiliaries in every state in the nation observe March 30 with events and kindnesses that include donations to the American Medical Association Education and Research Foundation (AMA-ERF), nursing and other health-related scholarships, letters of appreciation to medical society members, carnations for hospital staffs, school poster contests, health fairs, and numerous donations to nursing homes and hospitals. And this year, an additional emphasis has been placed on providing assistance to physician reservists serving in Operation Desert Storm. That the 58 years of activities honoring the quiet work of our nation's healers has received White House recognition is a bonus long overdue. □ Marion H. Geib

NEW MEMBERS

The Medical Society of New Jersey would like to welcome:

Atlantic County

Diego M. Fiorentino, DO
Oh Joon Kwon, MD
Frank W. Sindoni, MD

Bergen County

Nicholas V. Campanella, MD
Linda J. Corenthal, MD
Jeffrey B. Danzig, MD
David N. Feldman, MD
Bruce S. Goldenberg, MD
Mindy A. Goldfischer, MD
Bruce J. Haik, MD
Sadek K. Hilal, MD
Brad M. Herman, MD
Sergiusz I. Kaftal, MD
Joseph L. Klapper, MD
Darren T. Koch, MD
Lizabeth A. Kopp, MD
Myron M. Levitt, MD
Colette D. Lieber, MD
Lawrence I. Livingston, MD
Lewis G. Maharam, MD
Paul C. McCormick, MD
Malcolm H. Moss, MD
Cesar V. Nolasco, MD
Edwin V. Nolasco, MD
Brian E. Novick, MD
Todd D. Pascarelli, MD
Anna C. Pavlick, DO
Marc D. Polimeni, MD
Asmat U. Quraishi, MD
Mitchell J. Rubinoff, MD
Steven N. Sireci, Jr, MD
Jeffrey K. Steuer, MD
David C. Sundstrom, MD
Albert Tartini, MD
John M. Zimmerman, MD
Barry M. Zingler, MD

Burlington County

Jesse V. LoMonaco, DO
Mark G. Schwartz, MD
Moishe Starkman, MD
Robin W. Thornton, MD

Camden County

Gregg A. Bannett, DO
Nicholas A. Bertha, DO
David R. Brooker, MD
Ira D. Horowitz, MD
Ashokkumar B. Patel, MD
John T. Pericles, DO
Victoria P. Peters, DO
Howard I. Siegel, MD
Bruce B. Sloane, MD

Cape May County

William H. Hankin, Jr, MD
Jeffrey P. Tenner, DO

Cumberland County

Ralph Dauito, MD
Evan B. Krisch, MD
Michele A. Torchia, MD
Catherine L. Wisda, MD
Elizabeth M. Zadzielski, MD

Essex County

Mark J. Berger, MD
Louis J. Celebre, MD
David L. Garbowit, MD
Carol L. Kornmehl, MD
Maria Lania-Howarth, MD
Maryann Nicastro, MD

Gloucester County

Luisa E. Lehrer, MD
Ashfaque A. Unwala, MD

Hudson County

Sandra S. Valdez, MD

Hunterdon County

Gregory E. Broslawski, DO
John M. McGowan, MD

Mercer County

Ernest J. Cimino, MD
Edward J. Ford, MD
Khyati S. Majmundar, MD
Carmen J. Romano, MD
Leslie J. Salloum, MD

Middlesex County

Denise I. Beighe, MD
Pedro J. Cepeda, MD
Karyn J. Israel, MD
Edward S. Magaziner, MD
Kiritkumar S. Patel, MD
Jospeh M. Piacentile, MD
David L. Rubenstein, MD
Neil L. Youngerman, MD

Monmouth County

Michael G. Absatz, MD
Michael L. Arvanitis, MD
Joseph T. Barmakian, MD
Joseph E. Cauda, MD
Anthony De Tulio, MD
Steven A. Goldstein, MD
Jose G. Gonzalez, MD
Paul B. Jergens, MD
Christopher D. Johnson, MD
Young D. Kong, MD
Frank J. Laudonio, Jr, MD
Choong-Sung Nahm, MD
Karunambal Rajaraman, MD
Thomas F. Rizzo, MD
Lisa M. Zimmerman, MD

Morris County

Mary Beth Browne, MD
Alfred S. Casale, MD
Roy J. Cobb, MD
Lawrence Fabrizio, DO
Hal N. Ginsberg, MD
Martin A. Hirsch, MD
Kevin V. James, MD
Frank Iannetta, MD
Carol Irving, MD
Mark J. Rubinetti, MD
Charles M. Yarborough, III, MD

Ocean County

Christian Y. Chung, MD
Parvez Dara, MD
David F. Jadwin, DO
Mark Lehman, MD
Stephen L. Newman, MD
Joseph P. Pedicini, MD
Vijay R. Sankhla, MD

Passaic County

Dale R. Kozinn, MD
Sung Í. Lee, MD
Susan Mediterraneo, MD
Manglam Narayanan, MD

Somerset County

Richard D. Chen, MD
Pushpalatha S. Raju, MD

Sussex County

Kathleen A. Saradarian, MD

Union County

Geoffrey D. Chazen, MD
Michael M. Cohen, DO
David M. Hochhauser, MD
Maryann Huhn-Werner, MD
Glen S. Landesman, MD
Thomas D. Leopold, MD
Lawrence S. Meyers, MD
Thomas R. Nucatola, Jr, MD
Diego Saporta, MD
Gail Siber, MD

Warren County

Bharat K. Mehta, MD
Perla Sarayno-Sagge, MD

VIRAL DIAGNOSTICS

UMDNJ-Robert Wood Johnson Medical School Viral Diagnostic Laboratory now has completed its seventh year of operations. In 1990, a total of 2,082 specimens were submitted: 440 specimens were positive for viral isolations and yielded an isolation rate of 21 percent. The most common viral isolate remained herpes simplex virus with a total of 215 isolates and a positive yield of 49 percent. It was a record-breaking year for cytomegalovirus, a total of 132 patient speci-

UPCOMING SPECIAL ISSUES

Addiction

Guest Editor:
George Mellendick, MD, MPH

Sports Medicine

Guest Editor:
Paul J. Hirsch, MD

mens yielded an isolate. This number represents a substantial increase from previous years; this can be attributed to the surge of viral cultures performed on HIV positive patients. The respiratory syncytial virus was the third most common virus identified. The rapid antigen ELISA and cell culture methods were utilized; a total of 50 Respiratory Syncytial Virus (RSV) isolates were identified. The rapid antigen ELISA remains the only test offered for rotavirus and a total of 15 rotaviruses were detected during the first quarter of 1990. It was a good year for adenovirus compared to previous years; a total of 10 adenoviruses were isolated and confirmed via ELISA technology. Enterovirous remains the only virus for which a rapid confirmation method is not available; positive isolates are sent out to the state laboratory. Six herpes varicella viruses were isolated and now can be confirmed via immunofluorescence staining. It proved to be a mild year for parainfluenza and two type 3 viruses were identified. No influenza virus was isolated during the 1990 year. Confirmation for parainfluenza type 1-2-3 and influenza type A and B was established during the last quarter of 1990 utilizing Bartel's/Baxter immunofluorescence stains. The first influenza virus type B for 1991 has been isolated and was confirmed during the first quarter. We hope this information is of interest to the physicians of New Jersey. ☐ Lawrence D. Frenkel, MD, Director, Laboratory for Clinical Virology; Joseph C. Santoro, Supervisor, Laboratory for Clinical Virology.

Specimens Submitted for Viral Identification—1990

Total Submitted	2,082
Viruses Identified	440
Percent Positive	(21%)
Herpes Simplex Virus	215
Cytomegalovirus	132
Respiratory Syncytial Virus	50
Rotavirus	15
Adenovirus	10
Enterovirus	9
Herpes Varicella Zoster Virus	6
Parainfluenza Virus	2

LYME DISEASE STUDY

The Robert Wood Johnson Medical School–Lyme Disease Center is conducting a clinical trial for the treatment of Lyme disease. Patients with the Lyme disease rash, erythema chronicum migrans (ECM), may be eligible to participate. Qualifying patients receive free physical examinations, laboratory tests, and medication. Patients must be 12 years of age or older, and not allergic to penicillin. Women must not be pregnant or nursing. Please call Sandy Patella at the Lyme Disease Center, UMDNJ-Robert Wood Johnson Medical School, 908/937-7702. ☐

PLACEMENT FILE

The following physicians have written to the executive offices of MSNJ seeking information on opportunities for practice in New Jersey. We suggest you contact these physicians directly.

Cardiology

George D. Birmingham, MD, 3531 Salerno Ct., Apt. 5, Middleton, WI 53562. Mount Sinai 1984. Board eligible. Board certified (IM). Group or partnership. Available July 1991.

Internal Medicine

Thomas P. Hooker, DO, 2804 Sitios St., Tampa, FL 33629. Philadelphia College of Osteopathic Medicine 1984. Board certified; also, PUL. Solo or multispecialty group. Available July 1991.

Marc Kesselhaut, MD, 1 Rustic Ridge, C16, Little Falls, NJ 07424. St. George's University 1986. Board eligible. Solo or partnership in Mercer, Somerset, Burlington, Hunterdon, or Middlesex counties. Available.

M. Stekelman, MD, P.O. Box 900, Hightstown, NJ 08520. BSAS (Argentina) 1959. Also, gastroenterology. Board eligible. Available.

Obstetrics/Gynecology

Dennis Tumbokonm, MD, P.O. Box 476, Kimball, WV 24853. University of the East. Board eligible. Solo. Available July 1991.

Pediatrics

Donna Churlin, MD, 55 Montgomery St., Bloomfield, NJ 07003. UMDNJ 1987. Board eligible. Partnership or group in central New Jersey. Available July 1991.

Surgery

Nichlas J. Dudas, MD, 915 Princeton Ave., Philadelphia, PA 19111. UMDNJ 1986. Board eligible. Group or partnership.

Urology

Jeffrey L. Gevirtz, MD, 400 Narragansett Pkwy., Apt. SC7, Warwick, RI 02888. UMDNJ-Robert Wood Johnson Medical School 1986. Board eligible. Group or partnership. Available July 1991. ☐

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MSNJ WRITING COMPETITION

for INTERNS/RESIDENTS/ FELLOWS/STUDENTS

A **$500 AWARD** will be presented annually by the Medical Society of New Jersey to the intern, resident, fellow, or 4th-year medical student who submits the best paper on a clinical subject for the Society's 1991 Competition.

Entries should be "sponsored" by a faculty member, and all papers submitted should be of sufficient quality to be considered for publication in NEW JERSEY MEDICINE.

See page 367

THE FIRST ANNUAL EAST COAST BACK SYMPOSIUM CONSERVATIVE MANAGEMENT OF LOW BACK PAIN

SEPTEMBER 15, 16, 17, 1991
SHOWBOAT CASINO HOTEL, ATLANTIC CITY, NJ

Faculty: Arthur H. White, MD, Jeffrey A. Saal, MD, David J. Anderson, MD, Ralph E. Sweeney, Jr., MD, Charles N. Aprill, MD, Roy C. Grzesiak, PhD, Richard Salib, MD, Richard Erhard, PT, DC, Steven A. Stratton, PT, ATC, PhD, Sandy Burkart, PT, PhD, Florence P. Kendall, PT, Wayne W. Rath, PT, Charles T. Filippone, PT, Bruce Anderson, BS.

A symposium designed for the general medical practitioner, orthopaedist, neurologist, chiropractor, physical therapist and rehabilitation nurse specialist. This course is intended to assist participants with staying abreast of the most recent, scientifically supported, conservative treatment approaches and review of current diagnostic procedures available for low back pain.

Accreditation:

UMDNJ	14 Credit Hours, Category I
AAFP	12 Prescribed Credit Hours
AOS	12.5 Credit Hours Category 2-B
NJAPTA	1.3 Continuing Education Units
NJSNA	Credit has been applied for

This program is offered in cooperation with: The University of Medicine and Dentistry of New Jersey, Center for Continuing Education in the Health Professions.

Information: Maria De Francesco, Conference and Exhibitor Director, East Coast Continuing Education Center, Inc., 1585 Morris Avenue, Union, New Jersey 07083 (908) 686-0836, Fax: (201) 686-9250.

Acupuncture & Electro-Therapeutics in Clinical Practice

New York State Boards of Medicine & Dentistry 25-hour accredited seminar & workshop on latest theories & techniques of manual & electro-acupuncture, TENS & simple non-invasive diagnostic methods (including cardio-vascular, neuromuscular, central nervous systems & "Bi-Digital O-Ring Test"), applicable towards 300-hour requirement for certification to practice acupuncture, will be given periodically for licensed clinicians (with or without prior training) on 3-day weekends (Fri-Sun) of May 3-5, June 28-30, Sept. 20-22, Nov. 22-24, and Dec. 13-15, 1991, at Milford Plaza Hotel, 45th St. & 8th Ave., New York City.

The 7th Annual International Symposium on Acupuncture & Electro-Therapeutics will be held at Columbia University, School of International Affairs, 420 W. 118th St., N.Y. City, during October 17-20, 1991.

These meetings are co-sponsored by the International College of Acupuncture & Electro-Therapeutics & its official journal, Acupuncture & Electro-Therapeutics Research, The International Journal (published by Pergamon Press & indexed in 15 major indexing periodicals, including Index Medicus), Heart Disease Research Foundation; NY Pain Center; Electrical Engineering Dept., Manhattan College; Nordic Medical Acupuncture Society (Scandinavia); Schmerz Therapeutische Kolloquium (West Germany); Japan Bi-Digital O-Ring Test Assn.; Accredited toward Acupuncture Certification to practice acupuncture. Eligible for AMA CME Cat. I credit (about 40 credit-hours for the Symposium).

For information on meetings or submission or presentations of papers, contact Symposium Chairman, Prof. Y. Omura, M.D., Sc.D., 800 Riverside Drive (8-I) New York, NY 10032 Tel: (212) 781-6262 (10 am to 10 pm 7 days a week) or (212) 928-0658, Co-chairman, Prof. A.W. Cook, MD (516) 877-1821, or Bro. Michael Losco (212) 920-0162.

CONTINUING EDUCATION

CARDIOLOGY

June

26 **Clinical Arrhythmias**
1:30-2:30 P.M.—Runnells Specialized Hospital, Berkeley Heights
(AMNJ)

INFECTIOUS DISEASE

June

12 **Identification and Management of HIV Infection**
10:30-11:30 A.M.—Christ Hospital, Jersey City
(AMNJ and NJDOH)

19 **AIDS Update**
1:30-2:30 P.M.—57 U.S. Highway 1, New Brunswick
(Central New Jersey Medical Group and AMNJ)

21 **AIDS Training and Resource Program**
12 Noon-1 P.M.—Centrastate Medical Center, Freehold
(AMNJ and NJDOH)

26 **Diagnosis and Treatment of AIDS**
2:30-3:30 P.M.—Trenton Psychiatric Hospital, Trenton
(AMNJ and NJDOH)

July

25 **Identification and Management of HIV Infection**
2-3 P.M.—Welkind Rehabilitation Hospital, Chester
(AMNJ and NJDOH)

MEDICINE

June

4 **Internal Medicine Update and**
11 **Board Review**
18 5:30-7:30 P.M.—Cooper
25 Hospital/University Medical Center, Camden
(Cooper Hospital/University Medical Center)

5 **Prevention of Lower Extremity Amputations**
10:30-11:30 A.M.—Christ Hospital, Jersey City
(AMNJ)

5 **Urinary Incontinence of the Elderly**
10:30-11:30 A.M.—St. Mary's Hospital, Passaic
(AMNJ)

5 **Substance Abuse in the 1990s**
1:30-2:30 P.M.—57 U.S. Highway 1, New Brunswick
(Central New Jersey Medical Group and AMNJ)

6- **Emergency Medicine**
7 **Annual Meeting**
Trump Taj Mahal Casino/ Resort, Atlantic City
(American College of Emergency Physicians and AMNJ)

7 **Prevention of Lower Extremity Amputations**
11:30 A.M.-12:30 P.M.—Overlook Hospital, Summit
(AMNJ)

11 **Legal Autopsy: Case Presentation**
8:30-10 A.M.—Elizabeth General Medical Center, West, Elizabeth
(Elizabeth General Medical Center)

11 **Prevention of Lower Extremity Amputations**
1-2 P.M.—Marlboro Psychiatric Hospital, Marlboro
(AMNJ)

12 **Same-Day Surgery**
10:30-11:30 A.M.—St. Mary's Hospital, Passaic
(AMNJ)

12 **19th Scientific Session**
8:15 A.M.-2 P.M.—Quality Inn, North Brunswick
(NJ Thoracic Society)

13 **Diabetic Retinopathy**
1:30-2:30 P.M.—UMDNJ
(AMNJ)

13 **Common Eye, Ear, Nose, and Throat Problems**
2:30-3:30 P.M.—Greystone Park Psychiatric Hospital, Greystone Park
(AMNJ)

13- **Annual Meeting**
14 Trump Plaza Hotel and Casino, Atlantic City
(NJ Gastroenterological Society/NJ Society for Gastrointestinal Endoscopy)

19 **Hypertension**
10:30-11:30 A.M.—St. Mary's Hospital, Passaic
(AMNJ)

20 **Reconstruction Options after a Mastectomy**
5-6 P.M.—Shore Memorial Hospital, Somers Point
(AMNJ)

20 **Spectrum of Ischemia: Risk Stratification of the Coronary-Prone Patient**
5-6:30 P.M.—Somerset Medical Center, Somerville
(Somerset Medical Center)

21- **Communication**
22 **Enhancement Training Program**
All day—Marriott Seaview, Absecon
(MIIENJ and AMNJ)

24 **Diabetic Nephropathy**
1-2 P.M.—Woodbridge Developmental Center, Woodbridge
(AMNJ)

26 **Risk-Benefits Ratio of Depot Neuroleptics**
1:30-2:30 P.M.—Trenton Psychiatric Hospital, Trenton
(Trenton Psychiatric Hospital)

27 **Hyperthermia—Prevention and Care**
2:30-3:30 P.M.—Greystone Park Psychiatric Hospital, Greystone Park
(AMNJ)

July

3 **Current Concepts in ACLS—How To Run a Code**
1:30-2:30 P.M.—Central New Jersey Medical Group, New Brunswick
(AMNJ)

9 **Diabetic Retinopathy**
1-2 P.M.—Marlboro Psychiatric Hospital, Marlboro
(AMNJ)

11 **Diabetic Retinopathy**
2-3 P.M.—Welkind Rehabilitation Hospital, Chester
(AMNJ)

25 **New Developments in Emergency Care**
2-3 P.M.—Woodbridge

HU

Hahnemann University

Department of Medicine Grand Rounds 8:30 a.m.-9:30 a.m.

May 1991

MAY 1991

May 1, 1991
CHRONIC BRONCHITIS: A SYNDROME WE THOUGHT WE UNDERSTOOD
Stephen Rennard, MD
Larson Professor of Medicine
Section Chief, Pulmonary and Critical Care Medicine
University of Nebraska
Omaha, Nebraksa

May 8, 1991
THE LAW, THE HOSPITAL, THE PHYSICIAN: MEDICAL MALPRACTICE
Max Borten, MD, JD
Adjunct Professor of Law
Suffolk University Law School
Boston, Massachusetts

May 15, 1991
HEPATORENAL SYNDROME
Murray Epstein, MD
Professor of Medicine
University of Miami School of Medicine
Associate Director, Nephrology Section
Veterans Administration Medical Center
Miami, Florida

May 22, 1991
ADENOSINE: A NEW ANTIARRHYTHMIC DRUG
Bruce B. Lerman, MD
Director, Clinical Electrophysiology
Division of Cardiology
New York Hospital/Cornell Medical Center
New York, New York

May 29, 1991
CHOLELITHIASIS—NEWEST MEDICAL AND SURGICAL TREATMENTS
Teruo Matsumoto, MD, PhD
Professor of Surgery
Hahnemann University
Harris R. Clearfield, MD
Professor of Medicine
Director, Division of Gastroenterology
Hahnemann University

Hahnemann University Department of Medicine
Wednesday Medical Seminar Series
8:30 AM-3:30 PM

May 15, 1991
KIDNEY DISEASE, FLUID & ELECTROLYTES

Course Directors:	Allan B. Schwartz, MD Professor of Medicine Director, Continuing Medical Education for the Department of Medicine Hahnemann Universtiy	Charles Swartz, MD Professor of Medicine Director, Division of Nephrology Hahnemann University
Guest Faculty:	Murray Epstein, MD Professor of Medicine University of Miami School of Medicine Associate Director, Nephrology Section Veterans Administration Medical Center Miami, FL	Gary L. Robertson, MD Professor of Medicine and Neurology Northwestern University Medical School Chicago, IL
Topics:	• Fluid Balance • Sodium Imbalance • SIADH • Diabetes Insipidus	• Metabolic Acidosis & Alkalosis • Potassium Abnormalities • Edema and Ascites • Hepatorenal Syndrome

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Seminar Directors:

William S. Frankl, MD
Professor of Medicine
and Chairman
Department of Medicine

Allan B. Schwartz, MD
Professor of Medicine
Director, Continuing Medical Education
for the Department of Medicine

Location:

Classroom C (Alumni Hall)
2nd Fl. New College Bldg.
Hahnemann University (15th Street Entrance)
15th and Vine Streets, Philadelphia, PA

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Developmental Center, Woodbridge
(AMNJ)

ONCOLOGY

June

5 **Annual Meeting**
All day—The Manor, West Orange
(Oncology Society of New Jersey)

14 **Cancer Committee/Tumor Board**
11 A.M.-12 Noon—Wallkill Valley Hosital, Sussex
(AMNJ)

27 **Tumor Board Conference**
12 Noon-1 P.M.—Newcomb Medical Center, Vineland
(AMNJ)

PEDIATRICS

June

21-22 **Pediatric Life Support**
All day—Shore Memorial Hospital, Somers Point
(AMNJ)

26 **Pediatric Practicum 1991**
9 A.M.-4:30 P.M.—Ramada Inn, Clark
(AMNJ)

PSYCHIATRY

June

3 **Treatment of Narcissistic Personality Disorder in a Child**
8:15-10:15 A.M.—Nutley
(Essex Psychiatric Seminar and AMNJ)

4 **Family Therapy in an International Perspective**
8:30-10 A.M.—Elizabeth General Medical Center, West, Elizabeth
(Elizabeth General Medical Center)

4 **Tuberculosis**
1-2 P.M.—Trenton Psychiatric Hospital, Trenton
(Trenton Psychiatric Hospital)

5 **Cults**
All day—Carrier Foundation, Belle Mead
(Carrier Foundation)

6 **Clozapine—Treating Schizophrenia**
12 Noon-1 P.M.—Carrier Foundation, Belle Mead
(Carrier Foundation)

6 **The Boy Who Would Be King—Symbols and Transference**
8-10 P.M.—Hackensack Medical Center, Hackensack
(NJ Psychiatric Society)

12 **Psychopharmacology**
2:30-3:30 P.M.—Ancora Psychiatric Hospital, Hammonton
(AMNJ)

13 **Case Conference**
12 Noon-1 P.M.—Carrier Foundation, Belle Mead
(Carrier Foundation)

14 **Mitral Valve Prolapse and Eating Disorders**
10-11 A.M.—Marlboro Psychiatric Hospital, Marlboro
(AMNJ)

18 **Couple Dynamics in the Middle Years**
8:30-11 A.M.—Elizabeth General Medical Center, West, Elizabeth
(Elizabeth General Medical Center)

20 **Conflict over Child Custody**
12 Noon-1 P.M.—Carrier Foundation, Belle Mead
(Carrier Foundation)

21 **Psychiatry and the Law**
10:45-11:45 A.M.—Greystone Park Psychiatric Hospital, Greystone Park
(AMNJ)

23 **Patient Care Monitoring**
1:30-3:30 P.M.—Trenton Psychiatric Hospital, Trenton
(AMNJ)

July

11 **Dealing with Anger and Hostility**
12 Noon-1 P.M.—Carrier Foundation, Belle Mead
(Carrier Foundation)

18 **Autism**
12 Noon-1 P.M.—Carrier Foundation, Belle Mead
(Carrier Foundation)

PULMONARY

June

19 **Grand Rounds**
11:30 A.M.-12:30 P.M.—Newcomb Medical Center, Vineland
(AMNJ)

July

17 **Grand Rounds**
11:30 A.M.-12:30 P.M.—Newcomb Medical Center, Vineland
(AMNJ)

SURGERY

June

12 **Same-Day Surgery**
10:30-11:30 A.M.—St. Mary's Hospital, Passaic
(AMNJ)

20 **Reconstruction Options after a Mastectomy**
5-6 P.M.—Shore Memorial Hospital, Somers Point
(AMNJ)

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IN MEMORIAM

RALPH V. CIAMPA

At the untimely age of 47, Ralph Venanzio Ciampa, MD, died on January 22, 1991. Dr. Ciampa was born November 25, 1943, in Long Branch. After receiving his medical degree from the Faculty of Medicine University of Rome, Italy, in 1975, Dr. Ciampa completed a residency at Jersey Shore Medical Center, Neptune, in 1977. Dr. Ciampa earned his New Jersey and Connecticut medical licenses in 1978. A family practitioner, Dr. Ciampa resided and practiced in Long Branch and was attending at Jersey Shore Medical Center. Dr. Ciampa was a member of the executive board of Monmouth Medical Center, Long Branch, and of our Monmouth County component.

JOHN J. FLANAGAN

Retired since 1979, John Joseph Flanagan, MD, died at his home on December 29, 1990. Dr. Flanagan was born May 28, 1906, in Clarksburg, West Virginia. Dr. Flanagan earned his medical degree from Georgetown University School of Medicine, Washington, DC, in 1930 and his New Jersey medical license in 1934. Dr. Flanagan served an internship at Georgetown University Hospital and a residency at Jersey City Medical Center. An orthopedic surgeon, Dr. Flanagan maintained a practice in Newark and Spring Lake and was president of the New Jersey Orthopedic Society; a diplomate of the American Board of Orthopedic Surgery; a fellow of the American College of Surgeons; and a member of our Monmouth and Essex County components and of the American Medical Association. Dr. Flanagan was attending at Presbyterian Hospital, St. Michael's Medical Center, and the former Babies Hospital, all in Newark, and St. Mary's Hospital, Orange; an associate at St. James Hospital, Newark; and a consultant at Saint Barnabas Medical Center, Livington. During World War II, Dr. Flanagan was in the Army Medical Corps, serving as chief of orthopedic services at Kennedy General Hospital, Tennessee, and was awarded the Legion of Merit Award in 1946 for his surgical efforts.

NATHAN FRANK

A Jersey City physician for 50 years, Nathan Frank, MD, died January 14, 1991. Born in New York City, Dr. Frank earned his medical degree from New York University School of Medicine, New York, in 1930. Dr. Frank completed an internship at Jersey City Medical Center. An internist specializing in cardiology, Dr. Frank was assistant director of medicine at Jersey City Medical Center and at Christ Hospital and was on staff at Jewish Hospital and Rehabilitation Center and at B. S. Pollack Hospital, both in Jersey City. Dr. Frank was a clinical associate professor at UMDNJ, Newark; past-president of the Hudson County Heart Association; a fellow of the American College of Physicians; a member of the American Medical Association, of the American Heart Association, of our Hudson County component, and of the

New Jersey Heart Association; and a diplomate of the American Board of Cardiovascular Disease. Dr. Frank retired in 1983.

RICHARD L. FRANKLIN

A Hudson County general surgeon for over 40 years, Richard Louis Franklin, MD, died January 7, 1991, at the age of 71. Dr. Franklin, born on September 23, 1919, attended Columbia University College of Physicians and Surgeons, New York, receiving his medical degree in 1943. Dr. Franklin received his New Jersey medical license in 1945. Dr. Franklin was on staff at Christ Hospital, Jersey City; Fairmont Hospital, Jersey City; Jersey City Medical Center; North Hudson Hospital, Weehawken; and Palisades General Hospital, North Bergen. Dr. Franklin was a diplomate of the American Board of Surgery, and a member of our Hudson County component and of the American Medical Association. During World War II, Dr. Franklin served in the United States military. Born in New York City, Dr. Franklin resided in Jersey City and Waldwick.

CHARLES D. KUNTZE

A diplomate of the American Board of Obstetrics and Gynecology, Charles Donald Kuntze, MD, died January 1, 1991, in Cohoes, New York. Dr. Kuntze was born in New York City on October 26, 1922. Dr. Kuntze received his medical degree from New York Medical College, in 1946. After serving an internship at Flower & Fifth Avenue Hospital, New York, and residencies at Flower & Fifth Avenue Hospital and Metropolitan Hospital, New York City, Dr. Kuntze earned his New York medical license in 1951 and his New Jersey medical license in 1955. Dr. Kuntze practiced in New York City, Hoboken, and Fort Lee; served as a high school sports team physician; was a member of our Hudson County and Bergen County components, of the Medical Society of New York, and of the American Medical Association; was a fellow of the American College of Obstetricians and Gynecologists and of the American College of Surgeons; was a professor of obstetrics and gynecology at New York Medical College; and served in the United States Army Medical Corps. Dr. Kuntze was an attending at Holy Name Hospital, Teaneck, and at Flower & Fifth Avenue Hospital.

IRVING M. RIFFIN

President of the New Jersey Society of Anesthesiologists in 1957, Irving M. Riffin, MD, passed away December 29, 1990, in Boca Raton, Florida. Born in 1913 in New York City, Dr. Riffin graduated with a medical degree from New York University School of Medicine, New York, in 1938. Dr. Riffin completed his internship at St. Peter's Medical Center, New Brunswick, and his residency at the former Essex County Isolation Hospital, Belleville. Dr. Riffin maintained a family practice in Montclair for 45 years; performed research in caudal anesthesia for Hoffmann-La Roche Pharmaceuticals; was president of the medical staff and chief of anesthesiology at the former St. Vincent's Hospital; and was affiliated with Columbus Hospital, Newark, Montclair Community Hospital, and The Mountainside Hospital, Montclair. Dr. Riffin was a member of our Essex County component and of the American Medical Association, and a fellow of the International College of Surgeons and of the American College of Anesthesiologists. Dr. Riffin was in the Army Medical Corps.

EDITORIAL CRITERIA

NEW JERSEY MEDICINE is the official organ of the Medical Society of New Jersey. The goals are educational and informational. All material published is copyrighted by the Medical Society of New Jersey.

Content. The educational contents of each issue appear as scientific articles, based on research, original concepts relative to epidemiology of disease, and treatment methodology; case reports; review articles; clinical notes; state of the art reports; and special articles, that include evaluations, policy and position papers, and reviews of nonscientific subjects. Other topics include professional liability commentary; critical narration; medical history; therapeutic drug information; pediatric briefs; nutrition update; and opinions. Editorials are prepared by the editor and by guest contributors on timely and relevant subjects. The Doctors' Notebook section contains organizational, informational, and administrative items from the Medical Society of New Jersey and from the community. Letters to the editor and book reviews are welcome and will be published as space permits.

The principal aim in the preparation of a contribution should be relevance to diagnosis and treatment and to the education of patients and professionals. Preference will be given to authors from New Jersey and to out-of-state lecturers submitting a suitable manuscript based on a presentation made to an audience in New Jersey.

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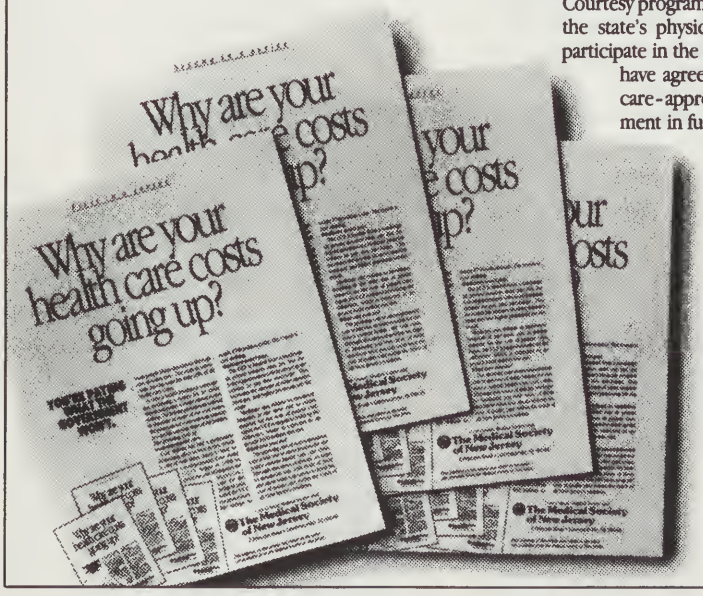
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Fourth in a series

Why are your health care costs going up?

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In a recent series of articles, we took a look at some of the reasons behind the rising cost of health care in New Jersey. DRG's. Government cost shifting. The growing cost of uncompensated care...It's a complex and frustrating situation. But there are some things we can do.

What doctors are doing

New Jersey's doctors are taking a number of steps to keep quality health care accessible and affordable to all our state's residents:

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What you can do

Preventive medicine in daily living is the best way you can keep your health costs down. Stop smoking. Lower your cholesterol. Watch your weight. Excercise regularly. And see your physician for periodic physicals.

What we all can do

All told, some $2.7 billion is being added yearly to the cost of health care in New Jersey as a result of government policies that shift costs to private patients. With that much at stake, it's time we all told our legislators how we felt about it.

Write your senator and congressman today. Ask them to repeal the unworkable DRG program and to support adequate funding of Medicare so that it can pay its fair share of the uncompensated care burden in our state.

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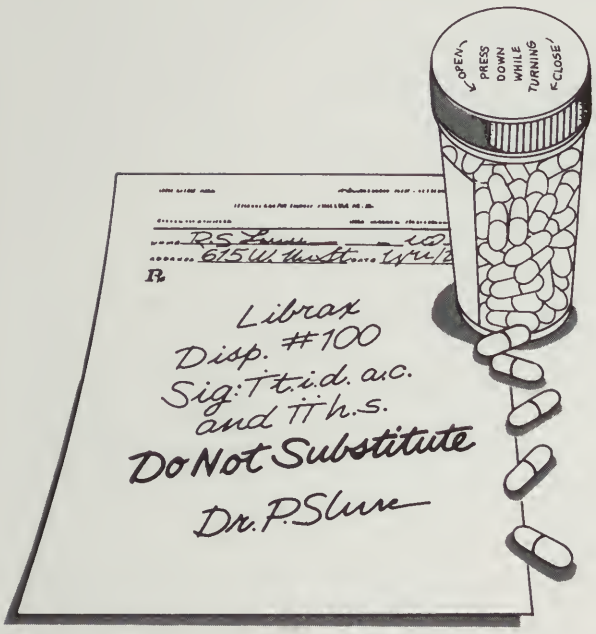
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Revised: February 1988

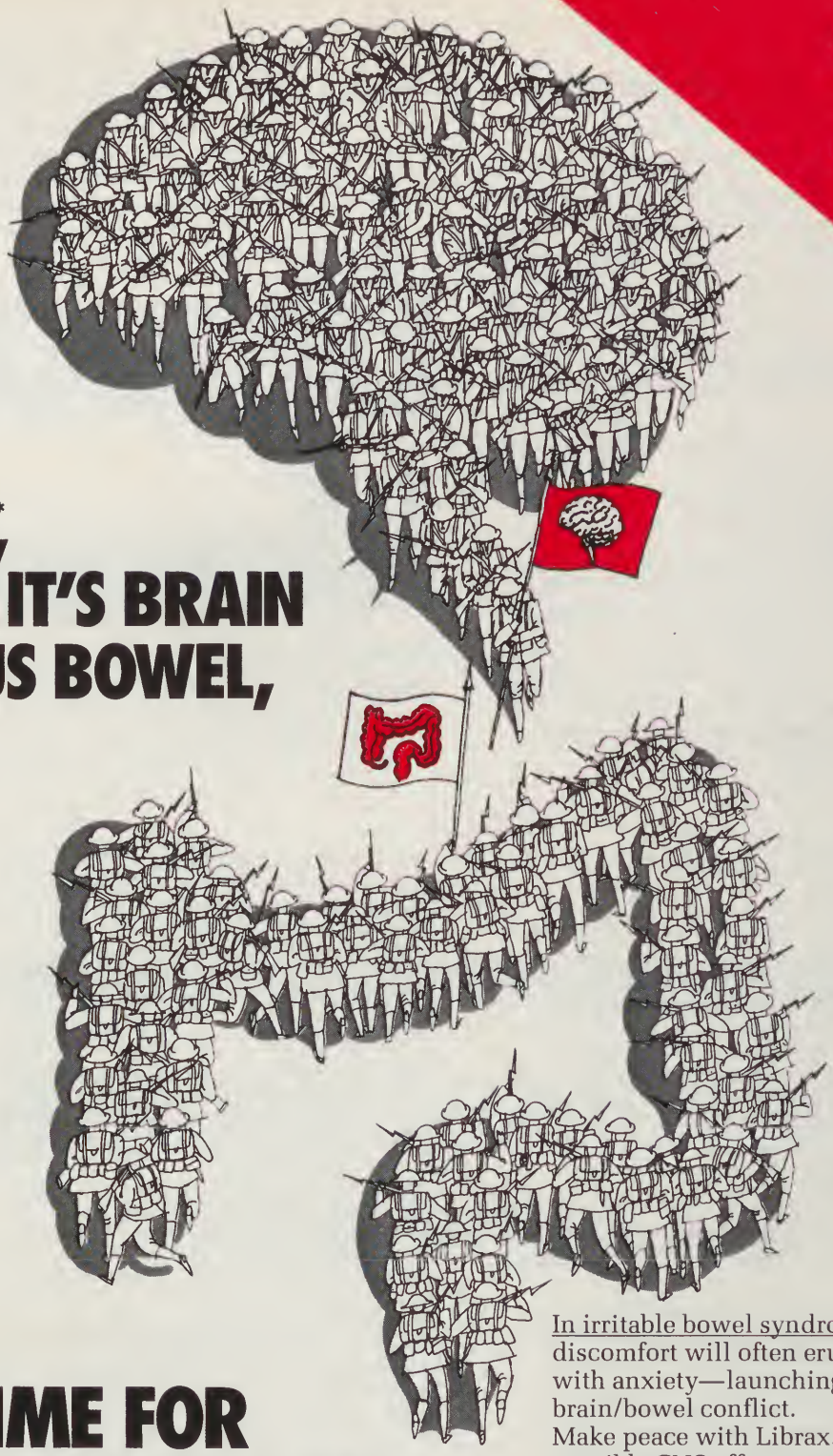
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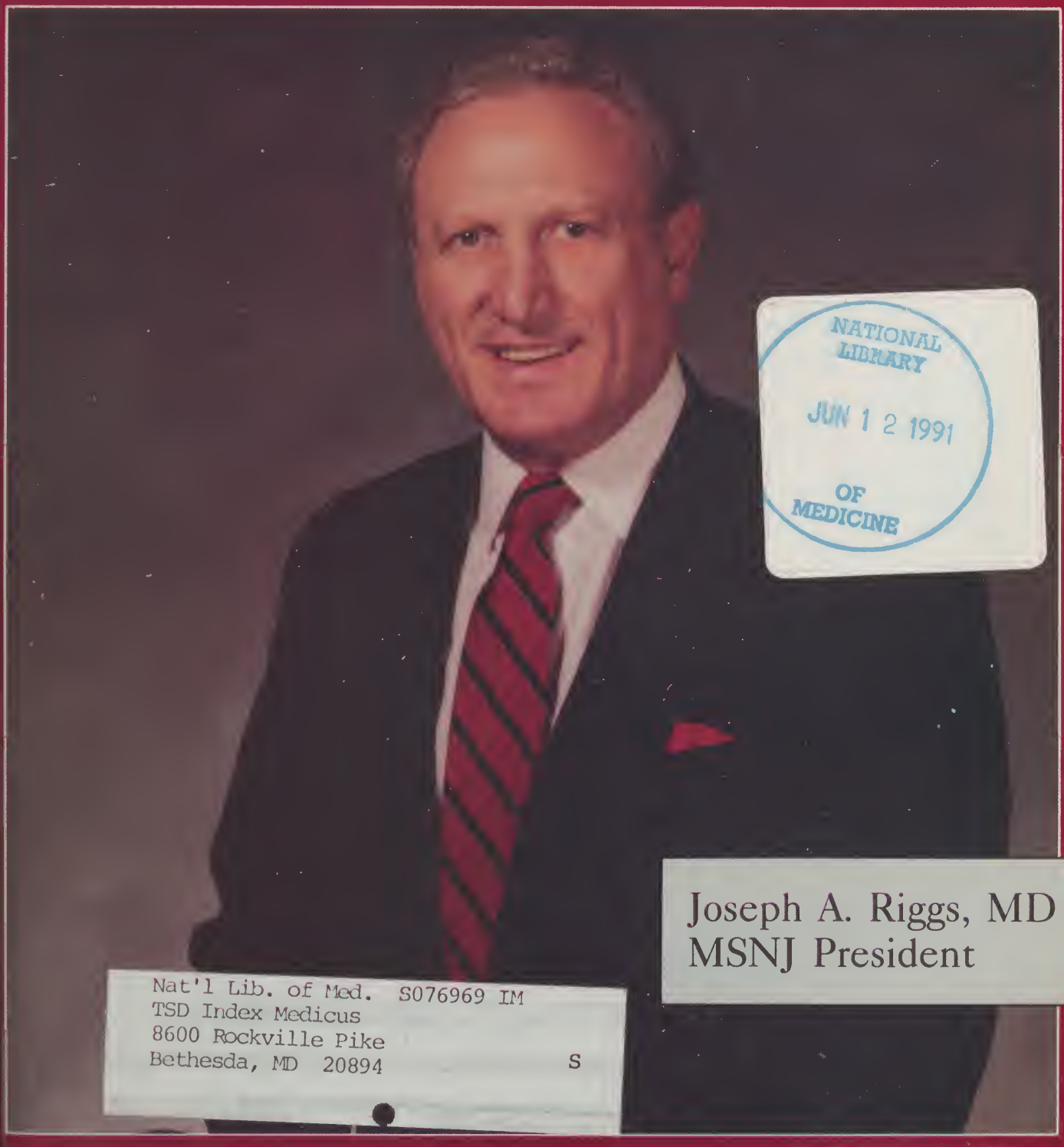
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June 1991

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Newswatch

HIV TESTING...

The Medical Society of New Jersey House of Delegates adopted a resolution on April 30, 1991, supporting universal testing for HIV on a voluntary basis for all hospital patients. The resolution also advanced universal testing of physicians and other health care personnel at periodic intervals. The MSNJ Board of Trustees referred the resolution to the Task Force on AIDS to develop a comprehensive report for consideration by the Board at its June 1991 meeting.

MALPRACTICE SURCHARGE APPEAL DENIED...

The State Supreme Court refused to grant an appeal requested by MSNJ to overturn the malpractice surcharge imposed by the commissioner of insurance. The Society and the Medical Inter-Insurance Exchange of New Jersey (MIIENJ) will explore the feasibility of legislative and regulatory correction. The surcharge will be imposed at rates from 2.5 percent to 5 percent per year over the next seven years to offset a $65 million deficit in the state government-operated Malpractice Reinsurance Association.

HEALTH MANPOWER SHORTAGE AREAS--PHYSICIAN INCENTIVE PAYMENTS

MSNJ has lodged a vigorous protest with the federal Health Care Financing Administration over the failure of Pennsylvania Blue Shield to implement physician incentive payments during 1990 and 1991 as required in federal law. MSNJ will pursue litigation unless the monies allocated are distributed to New Jersey physicians in a timely fashion.

GOVERNOR SIGNS SOCIAL WORKER LICENSING LAW...

Governor Jim Florio signed into law a bill that licenses social workers and permits them to practice psychotherapy. The governor and the Legislature ignored the objections of MSNJ and the New Jersey Psychiatric Association about the dangers inherent in the legislation. The governor believes the legislation will reduce the cost of health care.

HEALTH CARE REFORM LEGISLATION MOVES IN SENATE...

S-3251, the omnibus bill recommended by the governor's Commission, narrowly passed in the Senate. MSNJ still opposes two provisions in the legislation and will seek further modification or deletion in the Assembly. The Society is opposed to the general application of certificate of need to private practice as well as the ban on referral to a center in which a physician has an economic interest.

June 1991

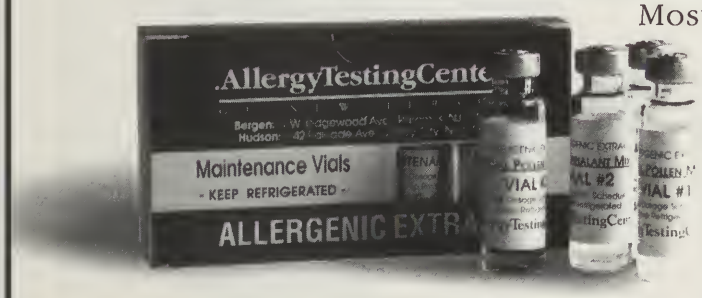
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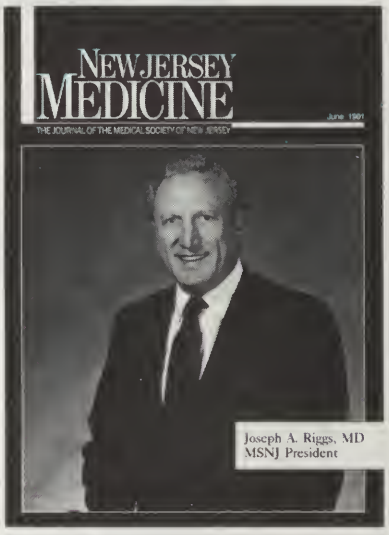
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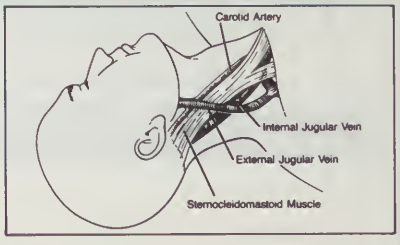
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MSNJ NEWSLETTER

CLIA-88

The Health Care Financing Administration (HCFA) has announced that the timetable for the final rule of CLIA-88 still stands at the end of this year. All physician office laboratories are included in these regulations. Gail Wilensky, PhD, HCFA chief, appears to be in favor of expansion of the number of regulatory test levels. The proposed rule has only two levels plus a waiver level. Concern still is being expressed over the lack of qualified medical technologists and technicians to meet the personnel requirements of level II laboratories. Dr. Wilensky agrees that matching the level of test complexity to the laboratory personnel standards will be a good practice.

The AMA has urged Congress to stop HCFA from collecting fees ($261/2 years) for provisional CLIA-88 certificates. The AMA stresses that physicians have not seen the final CLIA-88 standards and physicians do not have the information needed to make a decision whether to continue their laboratory services.

Darrol Loschen, MD, chair of the Commission on Laboratory Assessment (COLA) Committee spoke to the Medical Group Management Association. He advised the attendees to start looking for appropriate personnel, such as American Society for Clinical Pathologists–certified medical technologists to work in office laboratories that do a wide range of testing. He also suggested hiring a medical technologist or pathologist as a consultant to help get the office laboratory in order and prepared for regulation.

HAZARDOUS MEDICAL WASTE

New Jersey State Department of Environmental Protection inspectors are inspecting physician offices throughout the state. Since July 1, 1990, 769 physician office laboratories have been inspected and over 400 violations were cited. Since January 1991, 171 offices have been inspected and 51 offices were cited for 93 violations. The failure rate is alarming. The fines have ranged from $1,700 to $16,000. Compliance requirements can be found in the state manual that comes with the renewal application. Help also can be received by calling DEP. Physicians should appoint one employee to keep these records and periodically review them with the employee.

CORRECT CODING OF PHYSICIAN SERVICES

The new Medicare physician fee schedule, replacing the reasonable charge mechanism in place since 1966, will be effective on January 1, 1992. The Health Care Financing Administration (HCFA) already has taken certain measures to standardize the way payments are processed by the 34 Medicare carriers around the country.

One practice in need of standardization involves the variations in Common Procedure Coding System (CPCS) used to bill identical services. This was particularly true for surgical services. A common billing error was the reporting of two codes when one of the codes actually encompassed the full scope of the services provided. Another problem was reporting two or more codes when there was already a single

code that combined all of the procedures. Medicare does not make separate payment for procedures that are components of a more comprehensive group of services.

Carriers are required by regulation to insure that claims are paid appropriately and, if errors are found, to take appropriate corrective measures. Therefore, in order to insure correct coding, computerized edits were instituted at all Medicare carriers during February 1991 to identify billings that do not conform to the new requirements.

As an example, one of the edits currently in place will deny code 29870 (arthroscopy, knee, diagnostic, with or without synovial biopsy) when billed in conjunction with code 29875 (arthroscopy, knee, surgical; for infections, lavage and drainage synovectomy, limited). Carriers sent educational bulletins in January to notify physicians of the specific codes that will be "rebundled" into a more comprehensive code when billed for the same patient on the same date of service.

When incorrect combinations of codes are billed to Medicare, payment will be made only for the more comprehensive procedure. Payment will be denied for the other code or codes.

The initial edits are working smoothly. A second set of code edits, possibly as many as 500 edits, will become effective in early summer. These edits are being developed in consultation with the AMA and specialty societies.

Before the second edits are in place, Medicare carriers again will send a list to physicians of the correct codes and those that will be denied. The carriers will examine a sample of past claims before the coding changes are implemented. Those physicians who have a high volume of incorrectly coded claims will be contacted by the carrier.

If you should receive a notice of improper billing, you may want to check that the problem was not the result of a keying error, either on your part or on the part of the carrier. If it is, the carrier should be contacted. If not, then check the CPT-4 book or the carrier's bulletin to see if a single code does fully and completely describe the actual services performed. Carriers are available to work with physicians to resolve any problems or concerns in specific situations.

The standardization of correct coding procedures will not only insure uniform Medicare payment amounts in the present, but also will allow the development of an equitable fee schedule for the future. □ Maurice Hartman, Health Care Financing Administration

RINEBERG APPOINTMENT

Bernard A. Rineberg, MD, a member of our Middlesex County component, has been elected second vice-president of the American Academy of Orthopaedic Surgeons. Under the rules of progression in that organization, Dr. Rineberg will become president in two years. Dr. Rineberg is the former chairman of MSNJ's Committee on Long-Range Planning and Development.

HOSPITAL REIMBURSEMENT

The New Jersey State Department of Human Services, through the Division of Medical Assistance and Health Services, has submitted a proposal to the *New Jersey Register* concerning outpatient hospital reimbursement; a full text of the proposal will appear in a future issue. The proposal concerns reimbursement for outpatient hospital services on and after July 1, 1991, and establishes a 4.4 percent reduction in the interim payments for covered outpatient hospital services rendered to Medicaid eligible pa-

tients by general hospitals, special hospitals (classification AFB), and private psychiatric hospitals. The proposed rule to be published in the *Register* also provides that final settlements for covered outpatient services will be the lower of costs or charges minus 4.4 percent.

The reduction in reimbursement is necessary to comply with the expenditure levels recommended in the state fiscal year 1992 proposed state budget.

CASE MANAGEMENT

The New Jersey State Department of Human Services (DHS) has submitted a proposed new rule (the proposal) concerning case management to the *New Jersey Register*. The proposal will appear in a future issue of the *New Jersey Register*.

The provision of case management services under the Medicaid (Title XIX) program is a joint initiative of the Division of Medical Assistance and Health Services (DMAHS) and the Division of Mental Health and Hospitals under DHS. In general, case management services are designed for a target group of seriously mentally ill adults and children who are at high risk of hospitalization or deterioration in their functioning. Mental health case management services include aggressive community outreach to promote linkage to other mental health programs and provide long-term support. The proposal describes basic eligibility provisions, services, and basis for reimbursement, and prior authorization requirements, as appropriate. The proposal also sets forth the requirement for provider participation.

MEDICALLY NEEDY

The Division of Medical Assistance and Health Services has submitted the proposed readoption of the *Medicaid Only Manual*, NJAC 10:70, in order to comply with Executive Order No. 66. The Medically Needy Program extends limited Medicaid program benefits to certain groups of medically needy persons who meet the income and resource eligibility criteria. There are some minor technical amendments associated with the readoption. The Disability Review Section, that makes disability determinations for persons in Supplemental Security Income (SSI)-related eligibility categories, was moved administratively from the Division of Economic Assistance to the Division of Medical Assistance and Health Services. The regulatory amendment is just updating current practice.

There are changes in the budget unit. Generally, the budget unit is two; i.e. the pregnant woman and the baby she is carrying. However, the budget unit can be increased if there are verified multiple pregnancies. Also, if the pregnant woman is married, the budget unit shall consist of one additional person.

There is the possibility of the pregnant woman continuing her eligibility for six months beyond the prospective eligibility period if her 60 days postpartum exceeds the last day of the prospective eligibility period.

With respect to spend down, a medical expense paid by a state, territory or subdivision thereof, exclusive of Medicaid, could be included in spend down.

The text of the proposed readoption has been printed in the April 1, 1991, issue of the *New Jersey Register* at 23 NJR 964(a).

POVERTY GUIDELINES

The Department of Human Services has submitted an emergency rule and concurrent proposal that was effective as of April 1, 1991. The regulation expands eligibility for pregnant women and children up to the age of six up to 133 percent of the

federal poverty guideline. The regulations amend the *New Jersey Care . . . Special Medicaid Programs Manual* (NJAC 10:72), the optional category program in New Jersey. The text of the rule will appear in a future issue of the *New Jersey Register.*

CREDIT WATCH

Standard and Poor recently placed five New Jersey hospitals on credit watch due to concern over finances resulting from a lapse in the Uncompensated Care Trust Fund. The credit watch means that the rating service will review the financial status of the hospitals to decide whether their bond ratings should be maintained or lowered. Moody's recently downgraded the bonds of seven other New Jersey hospitals. Moody's was reportedly concerned that the New Jersey State Department of Health would be slow to adjust the hospitals' rates for uncompensated care as a result of the demise of the Uncompensated Care Trust Fund.

HUMAN SERVICES

In an effort to reduce the $500 million spent on contracts with social service agencies, a 32-member task force is attempting to develop a more streamlined and accountable system for the Department of Human Services. Operating inconsistencies exist between agencies within the $4.8 billion human services bureaucracy. Each agency has its own forms, monitoring and reporting requirements, and contract life cycles, some based on calendar year and others based on the state fiscal year. It is felt that if less energy was spent by the Department on administrative items, more time could be devoted to ensuring better program quality. Some items under consideration include multiyear contracts, and the development of common paperwork for community agencies that have contracts with more than one office in the department.

EMPLOYEE HEALTH INSURANCE

The Health Insurance Association of America has published their percentage estimates of the type of health plans carried by employees. Their findings were as follows: 49 percent fee for service, preadmission certification required; 18 percent fee for service, with no preadmission certification; 17 percent HMO; and 16 percent PPO.

1992 BUDGET CUTS

As part of the fiscal year 1992 Bush administration budget plan, biomedical research support grants have been eliminated. The grants totaled $22.3 million in fiscal year 1991 and funded a variety of small pilot projects not qualifying for full National Institutes of Health (NIH) grants. NIH reports the biomedical research grant program funded approximately 8,000 pilot projects in 1989.

MALPRACTICE DECISIONS RISE

Between 1988 and 1989, there was a 44 percent increase in the number of jury verdicts against hospitals and physicians on malpractice suits. According to the research director of Jury Verdict Research Inc., Hudson, Ohio, both the number of verdicts and the amount of awards for hospitals listed as a sole defendant declined. Physician verdicts, however, increased as to number and amount. Malpractice insurers suggest the decrease in the awards against hospitals is a result of state tort reform laws.

CONTRACT WARNING

The hospital industry has reacted with a number of questions regarding Health and Human Services Inspector General Richard Kusserow's warning regarding physician contracts that may represent potential violations of Medicare's fraud and abuse law. His original memorandum to the Health Care Financing Administration indicated that if physicians were required to pay hospitals more than "fair market value" for services provided by the hospital, such arrangements "are highly suspect although not per se violations of the statute." The memorandum also did not cite any evidence of Medicare over-utilization resulting from arrangements with physicians. According to hospital officials, where such arrangements are based on fair market value, such as examples provided by Kusserow, the guidance to assess such arrangements is inadequate.

DATA BANK FEES TO TRIPLE

The Department of Health and Human Services (HHS) is planning to increase the per-inquiry fee for accessing the computerized National Practitioner Data Bank from $2 to $6 in the near future. The fee increase is in response to underestimated administrative costs and more than expected inquiry volume, according to the Health Resources and Services Administration (HRSA), the agency administering the Data Bank. The Data Bank became operational on September 1, 1990, as a clearinghouse for information relating to physician malpractice suits, physician license suspensions, and revocations, as well as reported hospital actions against its privileged physicians.

HOSPITAL CHARITY CARE DEFINITION

Rep. William Coyne (D-PA) and Rep. Benjamin Cardin (D-MD), members of the House Ways & Means Health Subcommittee, have requested ProPAC to define "hospital charity care." According to Stuart Altman, ProPAC chairman, charity care has a variety of meanings. A clear definition of charity care may aid Congress in imposition of demands on nonprofit hospitals in order to maintain their tax exempt status.

NURSING AND PATIENT SATISFACTION

A study involving 115,000 patients in 188 hospitals across the country resulted in findings by Ganey Associates of South Bend, Indiana, that hospital patients link their satisfaction with the hospital more to the caring behavior of the hospital staff than to any other factors. The study recommends that "if there is a limited budget, attention paid to nursing issues reaps more financial rewards."

PRIVATE PENSION PLAN

To maintain their current lifestyle during retirement, physicians generally require assets capable of generating at least 75 percent of their pre-retirement income.

Unfortunately, the Tax Reform Act of 1986 imposed further restrictions and costs on many tax-qualified retirement plans that physicians in private practice traditionally have turned to for building sufficient retirement income.

MSNJ endorsed and introduced a Private Pension Plan for the exclusive consideration of member physicians. Designed specifically for physicians, the MSNJ Private Pension Plan offers

certain advantages over a qualified plan, solving the challenge of accumulating and sheltering wealth during peak earning years. Significant features of the MSNJ plan underscore the flexibility and liquidity of this unique deferred compensation retirement benefit.

The Private Pension Plan offers an opportunity to legally limit benefits to reward key members of a medical practice through tax deductible contributions up to 100 percent of salary. It also builds high tax deferred cash value available at any time, without restriction, beginning the first year. Because the plan has been structured as a whole life insurance contract, it includes a tax-free death benefit as well as tax-free income by utilizing the loan options. The plan is free from Internal Revenue Service approval and there are no IRS reporting requirements to add to administrative costs. In addition to serving as a cost-effective retirement benefit alternative to a qualified pension plan, it also can provide a "pension extension" when set up beside a qualified plan.

Special underwriting standards, available only to MSNJ members, are designed to save time and favor a physician's professional status.

The MSNJ Private Pension Plan is designed and underwritten by Mutual Benefit Life Insurance Company of Newark, A+ rated by A.M. Best and rated AA+ by Standard and Poor.

Smith Insurance Services, a division of D.F.S. & A., Inc., Lawrenceville is extending the plan. Smith Insurance Services and Donald F. Smith & Associates currently serve over 4,000 MSNJ member physicians through tailored health plans endorsed by the Society.

To review the specifics of the Private Pension Plan, members or their financial advisors may contact Robert N. Damato, vice-president, Executive Benefits Division of Smith Insurance Services at 609/895-1414 or 1/800/227-6484.

SILICONE OUTRANKS PACEMAKERS

The Department of Health and Human Services performed a national survey that found 11 million Americans, approximately 4.6 percent of the population, had medical device implants, in 1988. Most frequent are fixation devices such as wires, screws, and pins, followed by intraocular lens implants. A surprising study finding was that more Americans have silicone breast implants than pacemakers.

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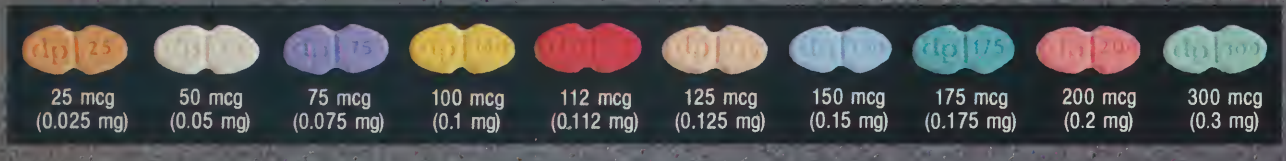
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LEVOXINE (L-thyroxine) tablets are indicated as replacement or supplemental therapy for diminished or absent thyroid function, resulting from functional deficiency, primary atrophy, from partial or complete absence of the gland or from the effects of surgery, radiation or antithyroid agents. Therapy must be maintained continuously to control the symptoms of hypothyroidism.

CONTRAINDICATIONS:
L-thyroxine therapy is contraindicated in thyrotoxicosis, acute myocardial infarction and uncorrected adrenal insufficiency.

WARNINGS:

Drugs with thyroid hormone activity, alone or together with other therapeutic agents, have been used for the treatment of obesity. In euthyroid patients, doses within the range of daily hormonal requirements are ineffective for weight reduction. Larger doses may produce serious or even life-threatening manifestations of toxicity, particularly when given in association with sympathomimetic amines such as those used for anorectic effects.

PRECAUTIONS:
Caution must be exercised in the administration of this drug to patients with cardiovascular disease. Development of chest pains or other aggravation of the cardiovascular disease requires a reduction of dosage.

Patients on thyroid preparations and parents of children on thyroid therapy should be informed that replacement therapy is to be taken essentially for life. They should immediately report during the course of therapy any signs or symptoms of thyroid hormone toxicity, e.g., chest pains, increased pulse rate, palpitations, excessive sweating, heat intolerance, nervousness, or any other unusual event. In case of concomitant diabetes mellitus, the daily dosage of antidiabetic medication may need readjustment. In case of concomitant oral anticoagulant therapy, the prothrombin time should be measured frequently to determine if the dosage of oral anticoagulants is to be readjusted.

Partial loss of hair may be experienced by children in the first few months of thyroid therapy, but this is usually a transient phenomenon and later recovery is usually the rule.

Drug Interactions — In patients with diabetes mellitus, addition of thyroid hormone therapy may cause an increase in the required dosage of insulin or oral hypoglycemic agents.

Patients stabilized on oral anticoagulants who are found to require thyroid replacement therapy should be watched very closely when therapy is started.

Cholestyramine binds both T_4 and T_3 in the intestine, thus impairing absorption of these thyroid hormones. Four to five hours should elapse between administration of cholestyramine and thyroid hormones.

Estrogens tend to increase serum thyroxine-binding globulin (TBG). Patients without a functioning thyroid gland who are on thyroid replacement therapy may need to increase their thyroid dose if estrogens or estrogen-containing oral contraceptives are given.

Drug/Laboratory Test Interactions — The following drugs or moieties are known to interfere with laboratory tests performed on patients taking thyroid hormone; androgens, corticosteroids, estrogens, oral contraceptives containing estrogens, iodine-containing preparations, and the numerous preparations containing salicylates.

Carcinogenesis, Mutagenesis, And Impairment of Fertility — A reported apparent association between prolonged thyroid therapy and breast cancer has not been confirmed. No confirmatory long-term studies in animals have been performed to evaluate carcinogenic potential, mutagenicity, or impairment of fertility in either males or females.

Pregnancy-Category A — The clinical experience to date does not indicate any adverse effect on fetuses when thyroid hormones are administered to pregnant women.

Nursing Mothers — Minimal amounts of thyroid hormones are excreted in human milk. Thyroid is not associated with serious adverse reactions and does not have a known tumorigenic potential. However, caution should be exercised when thyroid is administered to a nursing woman.

Pediatric Use — The incidence of congenital hypothyroidism is relatively high. Routine determinations of serum (T_4) and/or TSH is strongly advised in neonates in view of the deleterious effects of thyroid deficiency on growth and development.

ADVERSE REACTIONS:
Adverse reactions are due to overdosage and are those of induced hyperthyroidism.

OVERDOSAGE — Excessive dosage of thyroid medication may result in symptoms of hyperthyroidism, which may not appear for one to three weeks after the dosage regimen is begun. The most common signs and symptoms of overdosage are weight loss, palpitation, nervousness, diarrhea or abdominal cramps, sweating, tachycardia, cardiac arrhythmias, angina pectoris, tremors, headache, insomnia, intolerance to heat and fever. If symptoms of overdosage appear, discontinue medication for several days and reinstitute treatment at a lower dosage level.

Complications as a result of the induced hypermetabolic state may include cardiac failure and death due to arrhythmia or failure.

Dosage should be reduced or therapy temporarily discontinued if signs and symptoms of overdosage appear.

Treatment of acute massive thyroid hormone overdosage is aimed at reducing gastrointestinal absorption of the drugs and counteracting central and peripheral effects, mainly those of increased sympathetic activity. Measures to control fever, hypoglycemia, or fluid loss should be instituted if needed.

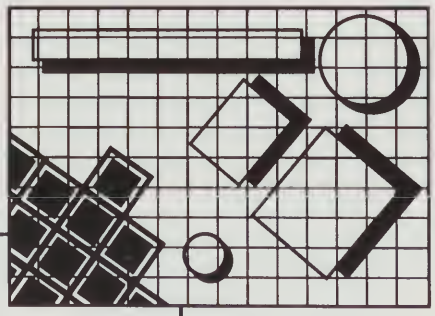
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PROFESSIONAL LIABILITY

SUICIDE LIABILITY

An emergency room physician and the professional corporation that employed him were liable for 80 percent of a $300,000 verdict for the wrongful death of a patient who committed suicide, the Louisiana Supreme Court ruled.

On Friday, July 3, 1981, the 22-year-old patient was taken to the hospital by his parents. He claimed he had taken 13 Quaaludes. The emergency room physician was told that the patient had been treated for depression by the family physician. The emergency room physician decided that voluntary admission to the psychiatric ward was appropriate. The patient signed a request for voluntary admission form, but the admission was blocked because the hospital could not verify that the family's insurance would cover psychiatric care.

Hospital policy required a $400 deposit in such cases, but the parents did not have the money. Although hospital policy also allowed the physician to waive the $400 requirement in cases of true emergency, the physician did not sign a waiver. Three nurses in the emergency room advised him of the waiver, and one nurse said that he thought the patient's condition presented an emergency.

The patient spent the rest of the night in his parent's home, but the next day he told his parents he needed some time alone and left to go to his own apartment. A few minutes later his parents found him with a self-inflicted shotgun wound to the heart. He died on the scene. A few days later, an undated suicide note was found in his dresser drawer.

A medical review panel found that the emergency room physician had failed to comply with the standard of care but that it did not cause the patient's death. A judge directed a verdict against the parents in a wrongful death action against the physician, his employer, and the hospital. An appellate court reversed for a new trial. At the second trial a jury returned a special verdict in favor of both the hospital and the physician, finding that neither was at fault. The appellate court found that the physician had not complied with the appropriate standard of care but concluded that the actions of the physician and hospital were not the cause of the patient's death.

On appeal, the Louisiana Supreme Court said that the parents proved that the emergency room physician failed to use reasonable care, diligence, and best judgment when he did not admit the depressed patient who was under the influence of drugs. The court found that the physician's conduct was a substantial factor in the cause of the patient's death. The court fixed damages as $150,000 for each of the parents, to be reduced by 20 percent for their fault. They did not use reasonable precautions, the court said. Besides not attempting to contact a psychiatrist or leave a message for the family physician, they let him leave their home unsupervised. (Reprinted from *The Citation*, 55:76, 1991, 61:132, 1991.)

DENTAL AIDS CASE

A Florida college student who steadfastly maintained that the only way that she could have acquired AIDS was from her treating dentist will receive $1 million in a settlement of her malpractice

case against the late Dr. David Acer, who died of AIDS on September 3, 1990. Continental Casualty Corporation of Chicago agreed to settle for policy limits on January 22, 1991.

It was the case of Kimberly Bergalis, now 23, that led to intensive investigations by the Centers for Disease Control (CDC) and Florida health department officials of possible transmission of the AIDS virus to patients by health professionals. Now a nationwide controversy is simmering over whether infected doctors should be required to tell patients about their illnesses and in what instances they should be allowed to continue performing certain procedures.

Bergalis also has a negligence suit pending against CIGNA Dental Health Plan, the program under whose auspices she received care.

A letter published by Dr. Acer just before his death announcing that he had AIDS and suggesting his patients be tested, prompted 591 patients to undergo HIV antibody testing. In the process, health authorities identified two seropositive patients, in addition to Bergalis. One patient was identified by matching the dentist's patient roster with the state's AIDS surveillance list, and another patient contacted CDC to report she was HIV-infected.

Dr. Acer was diagnosed with AIDS in September 1987. "In 1988, he received radiation therapy for Kaposi's sarcoma of the palate. He performed invasive procedures on patients after he was diagnosed with AIDS, and on a patient both before and after he was diagnosed with HIV infection," CDC said. (Reprinted from *Medical Liability Monitor*, 16:2, 1991.)

AIDS TRANSMISSION ISSUE

Two patients have filed malpractice actions against the Johns Hopkins Hospital and the estate of a deceased member of its medical staff. The suits charge that neither their surgeon, the late Rudolph Almaraz, MD, nor the hospital disclosed to them before they underwent surgery that Dr. Almaraz had AIDS.

Dr. Almaraz died last year; before his death, he told family members he had acquired the lethal infection from a blood spill during surgery on an AIDS patient.

Once the cause of death was known, the hospital immediately sent letters to 1,800 of the surgeon's former patients, mostly women with cancer or breast disease problems, informing them that Dr. Almaraz had died of AIDS. The letter reassured them that the risk of his transmitting the deadly infection to them was very small, but offered counseling and HIV tests to ease their minds.

Caught in a bind between the reality of dealing with the anxious and often angry patients of a surgeon who died of AIDS and what it termed a policy vacuum, Hopkins officials urged the national Centers for Disease Control, medical groups, health departments, and advocacy groups to "come to grips" with a critical societal issue—how to protect patients from a health worker infected with the AIDS virus while preserving the professional's privacy.

"We want help," said Hamilton Moses, III, MD, vice-president for medical affairs at the Baltimore teaching hospital. "We're dealing with an infectious disease that has been politicized to such a degree that rational decisions on behalf of the public's health and health care workers are impossible."

Dr. Moses said, "We are absolutely certain that at this very minute, there is at least one surgeon or other health care worker in every major urban hospital in this land who is HIV positive or who has AIDS."

Earlier nonbinding CDC guidelines on the subject of HIV-infected health workers say doc-

tors who know they carry the AIDS virus should consult with a panel of experts in their community to determine what procedures they should be allowed to continue to perform. Local hospitals are advised to impose any restrictions on a case-by-case basis. But, pressured by Johns Hopkins Hospital's criticism that current policies are vague, and also by nationwide concern over the apparent transmission of AIDS by a deceased Florida dentist to a young patient, CDC now is wrestling with new guidelines for health care workers to protect patients. Some fear that the guidelines might call for mandatory testing for the AIDS virus.

Although CDC states that the suggested new guidelines would not appear in the *Federal Register* for comment for several months, the word is that they will focus mainly on performance of invasive procedures by surgeons, obstetricians, dentists, and others. Procedures may be ranked according to degree of risk, based upon studies of other infectious diseases, such as hepatitis B.

Those opposed to mandatory testing say there is still no confirmation of the transmission of AIDS by Florida dentist David Acer to patient Kimberly Bergalis, although strains of the virus were so close that health officials suggest this was the case. They say any mandatory testing requirements would violate doctors' privacy, deprive some of their livelihoods, and make them less likely to want to care for AIDS patients.

The CDC says that 5,819 of the 153,000 reported AIDS cases—or 4 percent have involved health care workers: 637 physicians, 42 surgeons, 156 dentists and hygienists, and 1,199 nurses, as well as technicians and dieticians. Nobody knows how many carry the virus but do not have full-blown AIDS.

Currently, the Maryland health department and the CDC are doing followups of all the patients of the Johns Hopkins Hospital surgeon who agree to undergo HIV tests. At the same time, the Florida health department is doing tracer work with patients of dentist David Acer. Two of his patients have tested positive for AIDS, but it is not known whether they got the disease from high-risk activities or from the dentist.

Previously, the risk of transmission of AIDS by health workers to patients was deemed negligible. Now it appears it is time to determine with certainty what the degree of risk is.

Meanwhile, Johns Hopkins Hospital may face more malpractice suits stemming from a problem it did not know existed and other hospitals are fearful they may incur similar problems in the future. To date, most AIDS-related suits have been lodged against blood banks and blood suppliers, and, more recently, against physicians and hospitals involved in instances in which virus-contaminated blood was transfused. Now a new wave of suits may arise against hospitals and physicians as patients charge they were not informed if a medical staff member or health care worker has or had AIDS and has been permitted to continue to care for patients.

Then, of course, there is the future question of whether an insurer can require a potential applicant to certify that he is free of the AIDS virus before issuing a policy. Health insurers have been battling for this right and are making gains, despite the sensitivity of the AIDS issue. (Reprinted from *Medical Liability Monitor*, January 29, 1991.)

PROFESSIONAL LIABILITY

James E. George, MD, JD, is the director of the Department of Professional Liability Control, and Neil Weisfeld, JD, is director of special projects, Medical Society of New Jersey. If you have questions please call MSNJ at 609/896-1766. □

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BOOK REVIEWS

THE EYE IN SYSTEMIC DISEASES

Jack J. Kanski, MD; Dafydd J. Thomas, MD. Boston, MA, Butterworth-Heinemann, 1990. This text, written for the nonophthalmologist, is presented in outline form: very concise with little discussion of treatment modalities. It is useful for general clinicians as a reference guide of the eye findings in patients with systemic disease. The color photographs and illustrations are excellent. The section on neurological disorders should prove very helpful in simplifying the locations of complex lesions. This text provides an overview (160 pages) of the relationship of ophthalmological disorders in systemic illness. ☐ Donald J. Cinotti, MD

HEAD AND NECK IMAGING

Peter M. Som; R. Thomas Bergeron. St. Louis, MO, Mosby Year Book, 1991. In the second edition of this renowned textbook, the editors have employed the current imaging modalities of high-resolution computed tomography and magnetic resonance imaging in their cogent evaluation of the diseases of the head and neck. The volume starts with a review of embryology and a description of congenital lesions—with ample facial photographs accompanying the text. An extensive discussion of plain film radiography illuminates an analysis of the sinonasal cavity; in this chapter, the authors also address facial trauma. The mainstay of this book revolves around a comprehensive examination of the neck, larynx, and parapharyngeal space. These sections consist of a thorough and orderly review of the anatomy. Emphasis on radiological staging is stressed in the presentation of pathological states. As in the previous edition, the skull base receives in-depth examination.

The second edition of *Head and Neck Imaging* offers the physician an accomplished, readable exploration of the field. It is highly recommended. ☐ Neil B. Horner, MD

THE LUNG

Ronald Crystal and John West. This two-volume, reference book with chapters by 347 contributors from 13 countries reviews the basic foundations of pulmonology. The distinguished editorial staff surveyed "the whole territory of respiratory science," and they succeeded in accomplishing their mission.

A 79-page index, plus a detailed table of contents, is reprinted in each volume for easy reference. The graphs and tables, histologic sections, and electron micrographs are outstanding. Contributions by UMDNJ physicians Edelman and Riley are on a par with the high caliber of basic science presentations throughout this massive reference book. While any textbook can become outdated, this book will be current for quite some time, in large measure due to complete information on the latest research and a section on future directions.

This collection of papers covers cellular biology, environmental medicine, biochemistry, metabolism, physiology, biophysics, occupational medicine, pathology, pediatrics, cardiovascular and

pulmonary research, histology and microscopic anatomy, applied mechanics and biomedical engineering, hematology, tuberculosis and respiratory care, toxicology, infectious diseases, rheumatology, electron microscopy, immunopharmacology, aerospace medicine, surgery, public health, and hygiene. There is a tremendous scope of knowledge and the reader feels he is taking part in a monumental symposium discussing the gamut of pulmonary disease.

While some of the earlier chapters are perhaps too technical for the clinician, they serve as excellent source material for researchers. The chapter on V/Q relationships by Dr. West bridges the gap between basic physiology and clinical practice with the author's usual clear exposition. The average ten-page chapter has over 100 references. Later chapters are more clinically oriented; particularly outstanding are those on sleep disorders, the fetal and aging lung, high altitude and space problems, oxygen use and toxicity, mechanical ventilation, and ICU care. Discussions of ECMO and lung transplant touch on future frontiers.

The pricetag and the basic science emphasis may preclude the clinician from adding this text to his private collection. *The Lung* is a must for every medical library. Its contents will remain current for years to come as the complete reference book for teachers, researchers, and pulmonologists. ☐ Ellis P. Singer, MD

MEDIASTINAL SURGERY

Thomas W. Shields, MD. Philadelphia, PA, Lea & Febiger, 1991. Thomas Shields is professor of surgery at Northwestern University, and he has edited this 400-page book on mediastinal surgery. Since he has excluded discussion of all vascular structures, the esophagus, and the trachea, the volume has a rather narrow scope. Within that scope, however, the examination of the topics discussed are exhaustive and worthwhile. Since the structures discussed are limited to the anterior mediastinum and perivertebral areas, they include the thymus, mediastinal lymph nodes, mediastinal parathyroids, thoracic duct, and neurogenic structures of the mediastinum. These are discussed in terms of their normal structure and any tumors, cysts, or anomalies that may arise. The book is divided into ten sections: anatomy, noninvasive diagnostic investigations, invasive diagnostic investigations, surgical approaches, mediastinal infections, overview of mass lesions in the mediastinum, primary mediastinal tumors, mediastinal cysts, syndromes associated with mediastinal lesions, and special operative techniques. As would be expected in a highly specialized volume of this type, the discussions of the varying topics are detailed and complete. The photographs are well reproduced and well chosen. There is considerable variation in the style of the illustrations since many of them were drawn from other publications. Nonetheless, they maintain a good overall quality and some illustrations are outstanding.

Any surgeon involved with mediastinal lesions will benefit from owning this book and it also would be a worthwhile addition to the library of any cardiovascular resident who can manage to tear his attention away from the heart. ☐ Benjamin F. Rush, Jr, MD

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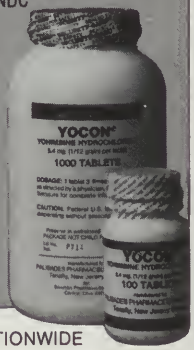
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References:

1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
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EDITOR'S DESK



HMOs TODAY

I read your editorial, "HMOs Today," and was appalled at your perceptions of HMOs, preventive medicine, and American medicine. All HMOs are not the same. Federally qualified HMOs must provide coverage according to federal guidelines and rather than being "unfair competitors" are actually at a disadvantage, since federal qualification mandates stringent benefit levels and other criteria. For example, federal qualification requires coverage for all pre-existing conditions. Many so-called "HMOs" are really only dressed up, discounted programs established by indemnity insurance companies that do not offer managed care, do not offer preventive programs, do not offer quality, cost-effective providers for their members to utilize, and should not and cannot be lumped with those HMOs that do. The several financially successful, well-managed plans also must be differentiated from those that were poorly run or sacrificed financial viability for a run at a larger market share. There are significant differences among HMOs.

Your statement, "It never has been shown that the health of a subscribing population has been improved by covering more preventive services," contradicts hard data on issues such as immunizations and prenatal care. As former Surgeon General Koop suggests, we must move away from an acute illness orientation towards preventive care.

Preventive childhood immunizations have been shown to be an extremely cost-effective tool and have been documented to prevent morbidity and mortality. There is little argument that the health of the subscribing population has been improved when an HMO provides coverage for immunizations. Other preventive programs that provide access to prenatal care that can help prevent high-risk situations and thereby prevent morbidity and mortality in both mothers and infants improves the health of a population. Preventive screening programs for breast cancer and colorectal cancer as pursued by responsible HMOs improve the health of a population. Your statement about preventive care is reactive rather than proactive.

You expressed the belief that the medical profession can influence lifestyles and society only tangentially and marginally. This is certainly contradictory to the training of primary care physicians and reflects a defeatist mentality. Anticipatory guidance at well child visits and annual checkups is directed at influencing lifestyle issues. Clearly these visits are more cost effective than an unnecessary T and A. Data demonstrate physician success in influencing smoking cessation and increasing the rate of compliance with mammography studies.

Your final point that the fat has been trimmed from the system also is not supported by the facts. Many articles continue to document that large numbers of procedures and tests are being "inappropriately" performed. A system that attempts to look at appropriateness as well as cost will aid the patient and our profession.

An HMO can be successful, help control health care costs, and promote better quality care than the general "standard of care" provided in this country and in this state. □ Howard D. Arkans, MD, Medical Director, HMO-NJ (Division of U.S. Healthcare)

We are delighted to print this letter, but as a "Letter to the Editorial" rather than as a "Letter to the Editor" and, therefore, are responding to it in this column, albeit briefly.

It is true that federally qualified HMOs have guidelines and requirements, some of which are needed to allow the inclusion of special groups such as Medicare recipients. Additionally, many of these federally qualified organizations were given start-up monies, derived from tax funds, and often over the objections of competing local practitioners. Nevertheless, you agree that some are poorly run and poorly managed, do not offer quality, cost-effective care, and will have difficulty in surviving. Your remarks confirm the accuracy of the comments noted in our February 1991 editorial.

The quotation, "It never has been shown that the health of a subscribing population has been improved by covering more preventive services," omitted the word "measurably"—a vital oversight. The statement was not plucked out of the air and is not original with us. If you have hard data to the contrary, please enlighten us; we will share this data with our readers. We did not refer to the value of preventive services. We referred to a "subscribing population" covered by these services. No one would gainsay the value of immunizations or other prophylactic measures, but they are certainly underutilized. Witness the recent measles epidemic in our area.

Dr. Koop is correct. Unfortunately, although we may have moved the profession from pure symptomatic care to curative care, we have not yet reached a satisfactory level of preventive care. We await it eagerly, because, despite our best intentions and efforts, societal problems in the environment, as noted, affect health and longevity more than many medical preventive activities. This is well recognized by MSNJ, shown in newspaper and magazine advertisements stating, "Preventive medicine in daily living is the best way you can help keep your health costs down. Stop smoking. Lower your cholesterol. And see your physician for periodic physicals."

Anyone who would deny that much fat has been burned from the system is just being pejorative. As Schwartz and Mendelson noted in the April 11, 1991, issue of *The New England Journal of Medicine,* "Our findings suggest that the era of easy reductions in the number of inpatient days, with the associated attenuation of rising costs, is largely over." It also is widely conceded that much of the remaining fat is related to medical liability, PRO type requirements, governmental regulations, diversity in standards of care, and the costs of complying. And "appropriateness" is a difficult term to define, despite it becoming a buzzword of the late 1980s.

Apparently, we have the drop on you; we know much about U.S. Healthcare, Inc., but you know little about the HMO background of the editor. Be assured, we are more knowledgeable than you think.

Finally, much of the time we are reactive, much of the time we are proactive (a peculiar term), and often we are iconoclastic, in both reactive and active moods, in an effort to stimulate. We seem to have succeeded.

Howard D. Slobodien, MD

P.S. According to *Healthweek*, U.S. Healthcare, Inc. was the sixth largest of the national managed care firms, ranked by enrollment as of January 1990, with a projected 1990 net income of $77.5 million. HDS

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1991 Inaugural Address: Keep on Hoein'

Joseph A. Riggs, MD

Dr. Joseph A. Riggs is the new president of the Medical Society of New Jersey. He presented this speech to the Medical Society of New Jersey House of Delegates on April 29, 1991, at the Society's 224th Annual Meeting.

I want to thank all of you for honoring me by choosing me to be the 199th president of the Medical Society of New Jersey. This address is being presented to you, the leaders of our Society, with whom I hope to work closely and to whom I will turn for counsel. I will be sensitive to your problems and needs, and stand together with you in our struggle to attain the best possible health care for all citizens of New Jersey.

However, I want this address to be directed to all physicians in New Jersey, not only you who are present today. I am calling on you, challenging you, to help me enlist all physicians in a massive grassroots effort, to become involved. We must work together and fight together, always united, because we are a family.

And speaking of family, on a personal note, my immediate family has been farming in southern New Jersey for 103 years. Through the years, we have all worked together on our own farm, through whatever God and nature brought. How well I remember when I was 7 years old and my Dad first allowed me to work on the farm. How excited I was when he showed me how to hoe. He taught me the difference between a potato plant and grass, and how to hoe away the grass. With pride, enthusiasm, and vigor, I started hoein' those mile-long rows of sweet potatoes. Toward the end of the day, after hoein' many rows with my brother and sister, I walked back and counted all the rows we had done. My Dad, who was on a tractor nearby, stopped. He came up to me and asked what I was doing. I told him I was counting all the rows we had done. He quickly made it clear to me that I should never look back at what had been done. Rather, he urged me to look at how much more there is yet to do. I'll never forget what he said: "Just put your head down and keep on hoein'."

Well, ladies and gentlemen, there is much hoein' to be done in medicine in New Jersey. The last decade has brought many changes in the national debate on health care, and these changes have moved the AMA and MSNJ: to look more closely at our health care system; to acknowledge the serious problem of access to care and rising health care costs; and to seek solutions based on professional responsibility.

As the AMA's James Todd, MD, said: "Today the reality is, not if the health care system is going to change, but how it is going to change!"

There are many changes ahead for New Jersey medicine. There will be dramatic changes in the way medical care will be delivered and paid for in the 1990s. Medicine in this state never will be the same. We know change often is necessary, but we must make sure that it is change for the better.

Medicine in New Jersey is a paradox. Never before has the capability of helping people been so great as it is in 1991. Yet, never has there been such dissatisfaction about medicine in general—so much dissatisfaction that there are many special interest groups that are becoming involved with health care policy. These include: a budget-driven government; a somewhat militant media; a stressed labor and business coalition; and concerned senior citizens.

Nevertheless, patients are happy with their personal physicians, mostly because we always have held firm to our commitment to consistently, confidently, and carefully deliver to our patients quality health care. What is the problem, and what are the solutions? It is easy to state the problem. There are too many people in New Jersey who are uninsured or underinsured, and cannot find access to affordable quality care. However, the solution is much more complex. All of

the parties that I just mentioned are trying to promote their own remedies, often without physician input, with focus on their own special interests.

Many ask, "What is the state of New Jersey doing, and what is the Medical Society of New Jersey doing to combat this health care crisis?" The state administration, under Governor Jim Florio and his advisors, is truly concerned about rising health care costs (12 percent of the New Jersey state budget). The governor also is concerned for the underserved, and formed a Governor's Commission on Health Care Costs in April 1990. The Commission's mandate was to recommend strategies to correct rising health care costs and replace the Uncompensated Care Trust Fund with a more cost effective, equitably financed system that would render better access to care. MSNJ had no problem with that goal.

However, except for some isolated instances, it rapidly became evident that MSNJ would have very little active input into the deliberations of that Commission. Knowing that government tends to overpromise, underfund, and shift the blame, MSNJ became more assertive; we formed our own Committee. While agreeing there is a need for health care reform in New Jersey, the Society sought a sound, structured, and more feasible system of health care. After months of deliberation, we introduced "Health Access New Jersey" in July 1990. It was presented in person to the governor in August 1990, and published in *NEW JERSEY MEDICINE* in October 1990.

"Health Access New Jersey" is patterned after the AMA's "Health Access America"; however, it is more specific to New Jersey's issues. It is the official position of MSNJ regarding health care reform in New Jersey.

It certainly is possible to find enough funds to provide proper health care to every person in New Jersey who needs it; however, there is something very wrong with the way health care dollars are being distributed.

There is something very wrong when the federal government suggests we cut $5.5 billion from the 1991 Medicare budget, especially after more than $50 billion in cuts have been made in the last decade. In New Jersey, the administration is supporting mandatory assignment, at a time when the 1991 limiting charges represent less than 50 percent of the usual and customary fee of a physician. Does anyone in the administration really look at the figures?

There is something wrong when nearly one million people in New Jersey have no health insurance coverage and are being dumped into hospitals under the Uncompensated Care Trust Fund, costing $850 million per year, and that does not include an additional $500 million in free care given by the physicians of this state each year. This is especially sad when 40 percent of this group are employed and another 20 percent are dependents of those employed, and they all should have insurance. An additional 30 percent should be and could be on Medicaid but they are not. Therefore, 80 to 90 percent of those persons in the Uncompensated Care Trust Fund are able to have coverage.

The Governor's Commission, with its 93 recommendations, and MSNJ, via "Health Access New Jersey," say they have solutions. While the goals of the Commission are similar to those of MSNJ, the methods of implementing them are wide apart.

The administration feels the future of any change hinges on one word: money. In New Jersey, health care costs represent 12 percent of the state budget, a budget that has nearly a $1.5 billion deficit. However, for physicians, our biggest concern is, and always has been, quality patient care. As Dr. Ralph Fioretti said in his inaugural address in 1985, "The health and welfare of our patients, not economics or politics or race or religion, shall be our first consideration."

The Commission report calls for a total revision of the health care delivery and reimbursement systems in New Jersey. They desire a managed health care system through a single payor system, a good portion of which would be under government control, and as Dr. Harry Carnes said in his inaugural address in 1986, "The American Medical Association and the Medical Society of New Jersey have stated that they stand for a 'pluralistic' system of medical care." The need for constructive solutions is beyond question. However, what is not needed is a total destruction of our current system of private practice.

The Commission calls for enacting major Medicaid reform. Perhaps a Medicaid-eligibility standard of 185 percent of the federal poverty level could be a goal that will allow for coverage of many uninsured persons (approximately 30 to 40 percent of the uninsured). MSNJ agrees with that goal. However, the Commission calls for all Medicaid patients to be placed in the Garden State Health Plan—a state-run HMO. This HMO has been in existence for five years and is less than successful. MSNJ feels that Medicaid patients will be more compliant if they have the opportunity to choose their physicians and hospitals, and this could be done—providing that physicians and hospitals are paid fairly and adequately for the services rendered.

The Commission had very little to say with regard to medical malpractice reform in New Jersey. Their position is, "The final resolution of the problem created by the medical malpractice system is beyond the scope of this Commission." That is absurd. Medical malpractice costs, including millions of dollars in increased premiums and, perhaps, more than a billion dollars in de-

fensive medicine, make up more than 25 percent of all health care costs in the state. And controlling these costs is beyond the scope of this Commission? "Health Access New Jersey" lists several meaningful medical malpractice reform measures, including structured payments, limits on noneconomic damages, specific statute of limitations, and certificate of merit. These reforms would be designed to lower the frequency and severity of speculative litigation, while preserving the rights of injured patients.

level risk pools that would guarantee health care insurance for those persons changing jobs, or those persons with a particular health problem.

"Health Access New Jersey" would ask physicians to encourage preventive health care and disease prevention. It asks for better communication with patients, and demands that physicians practice with the highest ethical standards.

Finally, the proposals in "Health Access New Jersey" present a serious challenge to the Administration and everyone

Never look back on what had been done. Look at how much more there is to do. Put your head down and keep on hoein'.

There are several other areas of agreement and disagreement with the Commission's recommendations that I will not discuss at this time. However, let me tell you what "Health Access New Jersey" proposes:

1. Ensure that most patients have the ability and freedom to choose physicians, hospitals, and health care systems they desire.
2. Sustain an excellent medical education system to attract the best and brightest students who eventually will assure the public of well-trained physicians in the future.
3. Nurture professional ethics, prudent judgment, and professional freedom.
4. Reduce the need for defensive medicine.
5. Develop practice parameters to help ensure that only high-quality, appropriate medical services are provided.

"Health Access New Jersey" also calls for action to solve the Uncompensated Care Trust Fund crisis by: increasing access to care by enacting Medicaid reform; creating health industry insurance pools for small employers, so that all employees and their dependents can have coverage; and encouraging state-

concerned. Are we really going to pay for access to care for all those who cannot provide for their care themselves?

I challenge you to do more than practice good medicine. I ask you to become more involved; to become patient advocates; to be kinder to the elderly; and to look for better ways to bring medical care to the poor and uninsured. These are revolutionary times in medicine. I challenge you to be part of the times and part of our future.

Make speeches, write articles, convince lawmakers, inform news reporters, inspire patients, and educate the public. This is my plan for you this year. We want to do whatever it takes to transform the potential power that physicians in this Society represent into active power. We must believe in, participate in, and become a part of organized medicine. Whatever our frustrations, whatever our anxieties, and whatever our angers, we always must remember that this is the most exciting, most exacting, and most rewarding profession. It definitely is a profession for which it is worth fighting.

At this time, I would like to share with you my plans for the coming year:

1. *Grassroots Network.* Develop a grassroots network of involved physicians. I plan to have all the leaders of local areas fully involved, and then urge them to get other physicians involved. To do this, I would like to establish a Council of County Presidents to meet in Lawrenceville twice a year with the executive committee and staff. Obviously, county presidents are busy in their local areas. However, I would like to get them more involved in statewide activities, rather than be isolated on a local level. Council meetings would serve to disseminate information and materials firsthand, making assignments for contacting all legislators, encouraging presidents to stimulate all of their members into more activity. It also would allow for county presidents to get to know one another better, to exchange ideas and thoughts. Likewise, I would like to hold a similar meeting with the leadership of every specialty society.

2. *Board Meetings.* All meetings of the Board of Trustees are open to any physician. Often we hear complaints that we are not reaching our members, that we are not affording our fellow physicians the opportunity to express themselves. One way to elevate morale and esprit de corps is to allow all physicians the opportunity to stand up and be heard. Therefore, I plan an open forum for physicians, to be held as part of the September and March meetings of the Board of Trustees. We will advertise this forum via the *President's Hotline*, by announcements in *NEW JERSEY MEDICINE*, and by insertions in the county bulletins. We want to hear from any physician who has something to say.

3. *Membership for Women.* New Jersey is fortunate to have as one of our own, one of the foremost women leaders in medicine today, Dr. Palma Formica, past-president of this Society and presently a member of the Board of

Trustees of the AMA. Another active member of our own Board of Trustees is Dr. Leticia V. DeCastro. With the advice and cooperation of these two individuals, and many others, I plan to write to every female physician in this state, asking those who are active to enlist others to become so, and urging those who are not active in organized medicine to please come and join us. There are approximately 450 women physicians who belong to both the Medical Society of New Jersey and the American Medical Association. But there are well over 2,000 female physicians in New Jersey who belong to neither organization. In 1965, less than 10 percent of physicians entering medical schools were women. By 1985, 33 percent were women. It is anticipated that by the year 2020, almost 50 percent of all practicing physicians will be women. Therefore, women physicians will not only be practicing physicians, but also will be deeply involved in leadership roles in our Society. Women physicians possess superior skills, strong personal drive, well-defined goals, and a deep desire to influence. Only when we have as many women percentage-wise joining organized medicine and participating in leadership roles will our job be done.

4. *International Medical Graduates.* The same applies to you. There are members of the Board of Trustees, county presidents, and several past-presidents of the Medical Society of New Jersey who are international medical graduates. Please follow their example and come join us.

5. *Medical Students.* The time to get physicians involved is not decades after they have entered practice. The right time is when they are in medical school. There is legitimate widespread anxiety among many students over their ability to finance their medical education. We must show them that we have a sincere interest in their welfare. We must view students not as empty vessels to be filled, but rather as candles to be lit. We must impress upon them, at a young age, how important it is to become members of student organizations and political action groups. With the cooperation of university officials, I plan to address the freshman class of all medical schools in New Jersey to give them this message.

6. *MSNJ Auxiliary.* All of us know that the Auxiliary makes untold and vital contributions to medicine. Our spouses have become an invaluable and irreplaceable part of our profession: spouse, friend, partner, and auxiliary member. We could not do without their love and support. I have asked for their help and cooperation in several areas. We could carry out legislative action and public relations together. We can have workshops and educational programs. They are an invaluable source of energy and help to us, and we plan to utilize and work closely with them.

7. *Increasing Membership.* Every president of the Medical Society of New Jersey has had the same special project—that of increasing membership. I hope to join with county presidents and leaders of specialty societies to make this a prime issue. Also, I will work closely with the officials of the Hospital Medical Staff Section, and ask them to give an update of Medical Society activities at each hospital staff meeting. We will present a video on "Health Access New Jersey." I will ask them to show the video and distribute literature so that every physician knows the official position of the Medical Society of New Jersey, and can share this information with patients and legislators.

8. *Councils and Committees.* A great deal of time and consideration has been given to selecting committees, using to full advantage the many talents available in our membership. I will ask each committee chairman to contact all members, to inform them of meeting dates for the year, and to inform them that all meetings will last only half a day—so they can have the remaining half day to practice medicine. This year we are striving for 100 percent attendance at our committee meetings.

9. *Senior Citizens.* Thanks to quality medical care and new technology, we are witnessing the graying of America and the graying of New Jersey. By the end of 1991, the number of people in New Jersey over age 65 will be approximately 1.1 million, 14 percent of the state population. New Jersey is ninth in the country in the number of people over age 65; therefore, it is not surprising that the elderly population in New Jersey accounts for approximately 35 percent of all health care costs. We have to reach out and show the elderly we care, and that we will take the extra time and effort to talk with them. Now is the time to tell them the truth about Medicare: that the government has decreased Medicare spending by $50 billion in the past decade. We must tell them that the government wants to keep the Medicare budget neutral. That means it cannot grow, in spite of the fact that there are 500,000 new enrollees added each year. We must tell them that the government is gutting our medical centers and undermining the relationship between patients and doctors. We must tell them that the government has substituted "provider" for physician and "consumer" for patient, and placed layers of red tape between the two. Finally, we must tell them we still are physicians and they are still patients—no matter what the government wants to call us.

The critical element in health care reform will be public support. Until the elderly recognize the problems and demand changes, legislators will not act. Therefore, it is time for physicians to enlist the public to fight the battle of freedom for patients and freedom for physicians. We must encourage patients to write and call legislators. Tens of

thousands of informed voters have more clout than ten thousand physicians. We have to recruit our patients to help fight the battle for better health care if we are going to be successful with "Health Access New Jersey" and our campaign to ensure the delivery of quality care to citizens in New Jersey. We all must get personally involved because political power is based at the grassroots level, and that means every physician in the state.

Finally, we must inform our elderly patients that of the $100 billion spent on Medicare each year, approximately one-half is spent in the last two weeks of a person's life. The Governor's Commission on Legal and Ethical Problems in the Delivery of Health Care has just published, "Advance Directives for Health Care," a pamphlet that helps direct a patient's wishes concerning medical care towards the last days of life. With the help of Dr. Ian Samson, chairman of the Senior Citizens Task Force, and with the help of the county societies, we plan to hold meetings throughout the state, educating and informing senior citizens of these concepts.

We are standing on the threshold of a new era, and it is my dream, my aspiration, and my hope that this year we will be a new MSNJ—a Society dedicated to improving health care in New Jersey, and a Society that needs to do more.

Physicians have a peculiar tendency to reject leadership and then expect miracles to happen. To you, the House of Delegates, and officers and leaders of this Society, I plead: Do not let your enthusiasm get dampened to the point where it erodes all that is good in medicine; and do not let your resources get thinned by the continuing conflicting and confusing demands placed upon us by our constituency.

These thoughts, ideas, and plans will not work unless all physicians become involved and work together. I realize that a president may be sworn in one year and sworn at the next year, and I realize that it is not always easy to begin over, to take advice, to keep on fighting, be considerate, to profit by mistakes, and to shoulder the blame—all in one year. And yet, with the help and cooperation of all of you, it can be done. Few people are successful unless other people want them to be and help them to be successful.

Nehemiah became a leader of his people at a time when they had terrible problems. Through his profound leadership, he inspired his people to action. Person by person, family by family, and community by community, they came together and overcame their adversaries. We must learn from the lessons of history that we cannot sit idly by luxuriating in our past.

We need to reach out to people and care about our patients with sincerity. We need new initiatives, increasing enthusiasm, and strong loyalty. We have to function as a new, united, and strong Medical Society: a Society that needs to ask, encourage, and enlist every physician—male and female, international medical graduates, young and old, every committee, every county, and every specialty society, every medical student, and every member of the Auxiliary—all pulling together in a massive grassroots effort to strengthen our health care system. We are family. Together we must keep on hoein'. ■

Dr. Riggs is the 199th president of the Medical Society of New Jersey.

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1991 Presidential Address

Douglas M. Costabile, MD

This year has been one of turmoil—created by various people and groups interfering with the practice of medicine: insurance companies, Medicare, the Governor's Commission on Health Costs, and legislators.

Decisions on treatment are being made from behind the desks of insurance carriers, PRO, and HCFA, and at the same time sapping our energy, initiative, and productivity. These nonproductive schemes have caused health care costs to soar and political decisions, therefore, have altered treatment patterns.

The profession of medicine has become paralyzed by those who practice medicine without licensure.

One asks, "How did the medical profession reach this crisis?" The cause of this crisis is due to the majority of physicians remaining silent despite warning that the tide was turning.

Political warfare requires doctors to be heard in the Legislature and become involved with those legislators who view ideas parallel to ours. It also takes a great deal of money and votes to have "the legislators" accept our views on medical matters.

I ask that you do not become another Rip Van Winkle. It is imperative that you awaken to the crisis before us for the sake of your patients and for your future in the profession of medicine.

We started 1991 with a 75 percent usual and customary fee for automobile accidents and no balance billings; a surcharge on our liability insurance; medical waste registration and haulage; an increase in medical licensure; and an increase in x-ray survey; the list invariably goes on.

Part of our suit against the Board of Physical Therapy was lost; physician assistants now are taking over the practice of medicine—that is just another burden to the long-suffering Medicare program and the insurance companies. Before you know it, physician assistants will be prescribing medications and performing operations.

Once again, the Uncompensated Trust Fund is facing the legislators. In 1987, doctors throughout the United States gave $10.9 billion in uncompensated care and last year doctors in New Jersey gave $500 million in uncompensated care. New Jersey physicians have set up a voluntary system to treat patients who have little or no insurance. Yet, none of this has been recognized by those who say "more is never enough." I can only ask, "Why is this profession, a profession that deals with the caring and healing of every individual in this world, regarded with such low esteem?"

The legislators blame physicians for the high cost of medicine, but they have failed to inform the public that it is mainly due to: outrageous settlements in malpractice suits; high liability insurance premiums that, in fact, are due to the unfair malpractice suits; new drugs being introduced into the market at a high and unfair cost to the public, yet, the government does not seem fit to regulate the drug companies; and administration costs of Medicare. Seventy percent of every dollar Medicare spends is in administration; only 30 percent goes to hospitals, doctors, and allied health professionals.

This year has been a trying one for me, as your president and chairman of the Board of Trustees. However, we will continue to fight—we will survive and our profession will once again be revered. Our new president, Dr. Joseph Riggs, will prevail.

I wish to thank the Medical Society of New Jersey Board of Trustees, and committees and council members who have worked so very hard this year on your behalf. The guidance and wisdom graciously given to me by Vincent Maressa is and always will be sincerely appreciated. My deepest thanks to Diana Gore, Marie Fisher, and all the other dedicated employees at the Medical Society of New Jersey for the help and kindnesses extended to me during my presidency. All these people have been so instrumental in making my year as president a rewarding experience—an experience that will live with me the rest of my life.

To all of you my thanks and God's blessings to you. ■

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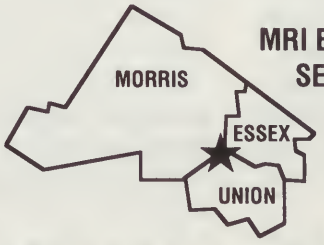
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Year 2000: Better Health for New Jersey

Frances J. Dunston, MD, MPH

This speech was presented on April 28, 1991, by Dr. Dunston at the Medical Society of New Jersey Annual Meeting. The New Jersey Commissioner of Health challenged physicians to make New Jersey a leader as we head toward better health for everyone by the year 2000.

Thank you for this opportunity to address the House of Delegates of the Medical Society of New Jersey. It is not every day that I get the chance to speak with practitioners such as yourselves, people who every day must confront the challenges and opportunities of caring for millions of New Jerseyans. Much of the time, I deal with people who are far removed from the problems of health. It is good to be with a real "hands-on" crowd for a change.

It is good news you are all here today. But, unfortunately, there is bad news as well. There is a broad array of problems in which we need your help and the help of others like you. You deal with health and disease every day. You understand the value of early intervention. Many of you are on the cutting edge of a national, even international, movement towards health promotion and disease prevention, a movement that seeks to make people's lives longer, fuller, and happier as the economic consequences of sickness and disability also are reduced. This movement has gained momentum, but we need your help.

A few facts: This year, as a nation, we will spend over $600 billion on health care. By the year 2000, this country will spend a staggering $8 trillion on health care. Some of that money will be spent wisely, and some will not. And you know that very little of it will be spent on prevention. Despite the best efforts of thousands like yourselves, the amount of resources being used to avoid death and disease is only slowly increasing. Opposition to this shift, to this change in focus, is unfortunately very strong. How many times are we asked to prove that it is worth it to do mammograms; that it is worth it to make sure our children receive *Haemophilus influenzae* vaccines; and to prove that it makes sense to promote the use of seat belts by automobile occupants? We know these things work, but still there is a constant litany of resistance to prevention, that often must take a back seat. There are many who think physicians themselves are disinterested in prevention—because it may hurt their income. But certainly there is enough sickness and suffering to go around.

One might even think there is no need for us to worry about prevention, that somehow it is just not important. The numbers do not bear this out. We know that almost a quarter of the people in this state still smoke and most of our citizens do not know whether their blood pressure is high or normal. We know that thousands of children continue unvaccinated, without a basic ongoing source of primary care and that our current measles epidemic is but a symptom of this condition. And we know that even as the infant mortality rate falls slowly across the state that, in some areas, including the city that lies right outside this beautiful, glittering hall, this rate is not only increasing, but it has reached shocking and embarrassing levels. It is brutally apparent that in the area of prevention we are doing far too little far too late and people are dying as a result.

It also should come as no surprise that the poor suffer the most in a system that pays short shrift to prevention and primary care. The effects of this crisis, of a structure that may allow tertiary care when a disease is far advanced, are seen mostly among the least privileged. Those who are most vulnerable pay the price.

The effects of this vulnerability can be seen in a most disturbing trend, one that was highlighted recently in "Healthy People 2000," the publication of the United States Public Health Service. There is a great disparity in the health status of the rich and

poor, and of whites and minorities. These inequities, present certainly since the beginning of our nation, have, if anything, widened in recent years. We know from several studies that those with lower income and those without insurance, many of whom are working people, have poorer health status. Their children are more likely to die in the first year of life, they are more likely to die of cancer, or to have uncontrolled hypertension. Despite this, we also know that the poor are less likely to see a physician and thus less likely to enjoy the benefits of prevention or acute intervention. In poorer health and blocked from reliable sources of care, the poor and the underserved are caught in a vise.

We need your help. As practitioners, you must build modern clinical preventive medicine into your daily routine. Too many physicians continue to lag in this area. We must obtain a psychosexual history from our patients, ensure that they undergo breast examinations when needed, and stress the need for a vaccination for pneumococcal pneumonia. There are a host of other things as well. The point is that we must practice what we preach.

We also need you to continue to provide free and reduced-rate care to our citizens, as many physicians of this Medical Society already do. I am very grateful for this, and I know millions of New Jerseyans thank you for the indigent services provided by physicians across the state.

But your role extends beyond that of the clinician. Ours is a noble profession, and we have always been at the leading edge of societal responsibility. Each and every one of you is a community leader by virtue of his standing as a physician. You must serve as advocates for health promotion and disease prevention. That can take many forms. It could mean letting your board of freeholders know how important it is that there be well-marked intersections with traffic signals. It might mean that you take the lead in ensuring that every woman in your town knows where she can get affordable prenatal care, or it could mean that you bring your local education officials to understand how important it is that we have real health education in our schools. Some of you already are helping us define the future health agenda of New Jersey by participating in the local community focus groups across the state as we create New Jersey's response to the national "Year 2000 Health" objectives. I thank you for all of your help in these efforts as well as others that assist me and my department in plotting a course for the future. Your positions and status in society make you ideally suited to be agents for positive change. As physicians you have demonstrated that you are concerned with the functioning not of just one organ system, but are worried about whole people and groups of people as well.



Dr. Frances Dunston

In order to meet the basic clinical preventive needs of our population, I'd like to see more people interested in primary care because clearly that is where we have needs. Recent studies have shown that the high educational debt for graduating medical students may be a major factor in terms of their future career choices. The unfortunately lower compensation for family physicians and other primary care doctors is working against this regard as these students "in hoc" choose higher paying specialties. We have supported, and will continue to support, legislation that will establish a loan repayment program for young primary care doctors who practice in underserved areas. Hopefully, in some way, this will bring the young doctor back to primary care. This especially is important now as we need physicians who can play a larger role in the prevention and treatment of AIDS and who can help us address the particularly severe health problems of minority citizens. Without this, any "prevention" policy will remain just that—a policy.

This is all a big challenge. It won't be easy. But we can take heart from a few things. There is movement towards making this a state of healthier people. From the pinnacles of power down to our smallest communities, people are realizing that they can make a difference through prevention and that the tools to do so are present. Indeed, it is no mystery. We know what has to be done and we know how to do it. All that remains is to develop the resolve needed to carry us forward. I challenge you, all of you, to be a part of this and to make medicine in New Jersey a leader as we head toward better health for all of our people in the year 2000. ■

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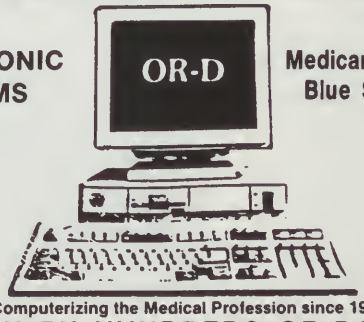
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Nuclear Medicine and Pediatric Nephrology

Margaret LaManna, MD
Edward J. Mueller, MD

Radionuclide cystography and renal scintigraphy are the diagnostic procedures of choice in conjunction with ultrasonography in the workup of pediatric urologic or nephrologic patients. Two interesting case reports—a six-month old and a three-month old—are presented.

The first patient was a six-month-old white male. At one day of age, an ultrasound demonstrated bilateral hydronephrosis greater on the right (Figures 1 and 2). A repeat ultrasound, at nine days, showed the bilateral hydronephrosis with a question of bilateral dilated ureters. The patient then was referred for a nuclear cystogram and a renal scan.

Direct radionuclide cystography was performed following the instillation of 1.0 mCi of technetium-99m (^{99m}Tc) into the bladder via a #5 French feeding tube. Sequential scintiphotographs of the bladder and abdomen were obtained following distention of the bladder with 50 cc of normal saline. In addition, 30 K oblique images were performed. Examination of the study with computer analysis demonstrated no scan evidence of ureterovesical reflux. Several days later, sequential scintiphotographs of the abdomen were obtained following the intravenous injection of 3.0 mCi of ^{99m}Tc diethylenetriamine-pentaacetic acid (DTPA). Computer analysis of flow and function of the kidneys was performed (Figures 3A, 3B, and 3C).

Examination of the study demonstrated the kidneys were enlarged but normal in position and configuration. There was slight diminished left renal perfusion. There was delayed transit of the radiopharmaceutical into the pelvicalyceal collecting systems bilaterally. Delayed images were performed up to three hours. The bladder was promptly visualized. There was no scan evidence of mechanical obstruction. These findings were in keeping with asymmetric bilateral hydronephrosis.

At two months, a renal flow study was performed following injection of 2.8 mCi of ^{99m}Tc DTPA. Examination of the study demonstrated the kidneys to be normal in size, position, and configuration. Renal perfusion was symmetric. There was delayed transit of the radiopharmaceutical into the pelvicalyceal collecting systems. There was prominence of both lower pole calyces. The bladder was promptly visualized and there was no scan evidence of mechanical obstruction (Figures 4A, 4B, and 4C). The infant continued to do well, with normal blood urea nitrogen (BUN) and creatinine (CR). At six months, a renal flow study was performed following the injection of 3 mCi of ^{99m}Tc DTPA. Examination of the study demonstrated the kidneys to be normal in size, position, and configuration. Renal perfusion was symmetric. At approximately 12 minutes, postradiopharmaceutical injection, 10 mg of Lasix® was administered intravenously. There was normal transit of the radiopharmaceutical into the pelvicalyceal collecting systems bilaterally. There was no scan evidence of mechanical obstruction. The asymmetric bilateral



Figure 1. Ultrasound, day 1, demonstrating significant right hydronephrosis.

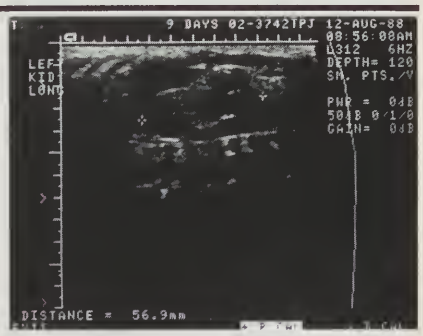


Figure 2. Ultrasound, day 1, demonstrating left hydronephrosis, less prominent than the right.

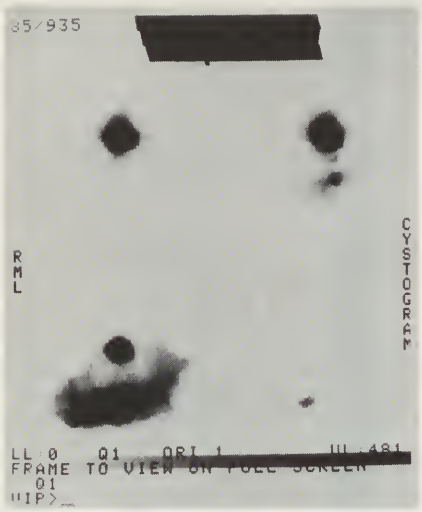
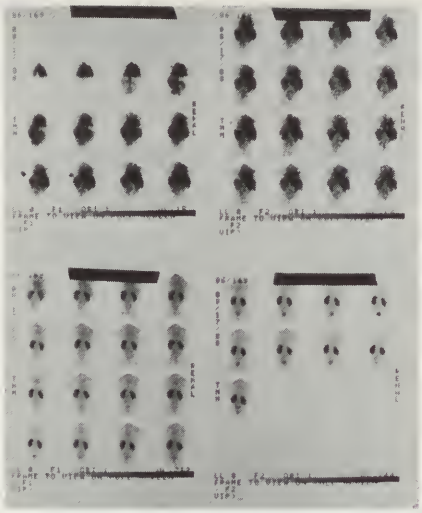
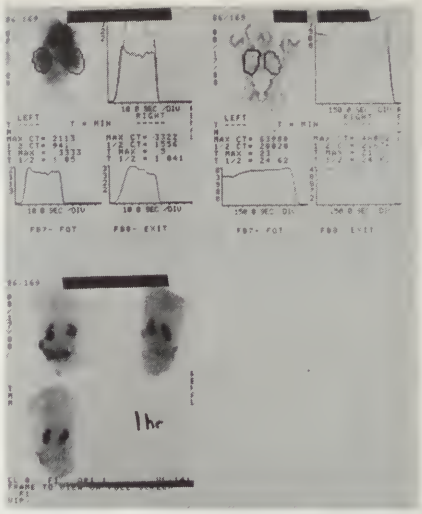


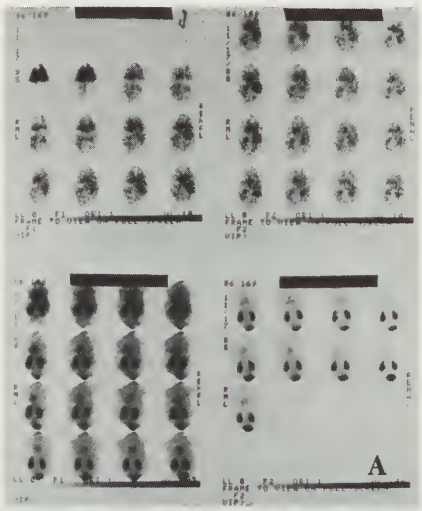
Figure 3A. Direct radionuclide cystography was performed following the instillation of 1.0 mCi of ^{99m}Tc into the bladder via a #5 French feeding tube. Sequential scintiphotographs of the bladder and abdomen were obtained following distention of the bladder with 50 cc of normal saline. The 30 K posterior oblique images demonstrate no scan evidence of ureterovesical reflux.

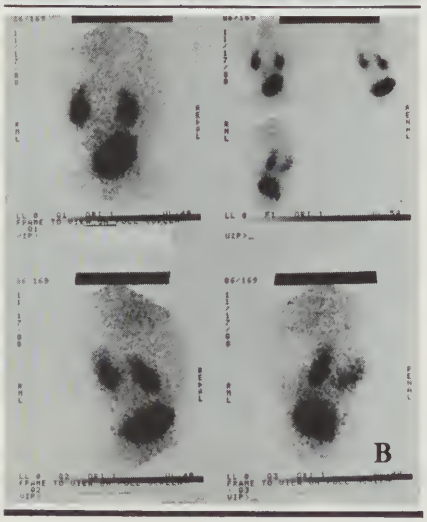


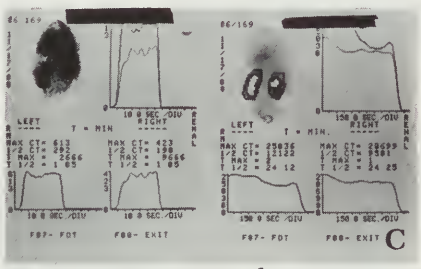


Figures 3B and 3C. Sequential scintiphotographs of the abdomen were obtained following intravenous injection of 3.0 mCi of ^{99m}Tc DTPA. In addition, computer analysis of flow and function of the kidneys to be enlarged but normal in position and configuration. There was slight diminished left renal perfusion. There was delayed transit of the radiopharmaceutical into the pelvicalyceal collecting systems bilaterally. Delayed images were performed up to three hours. The bladder was promptly visualized. There was no scan evidence of mechanical obstruction.

The findings for this patient were in keeping with asymmetric bilateral hydronephrosis.





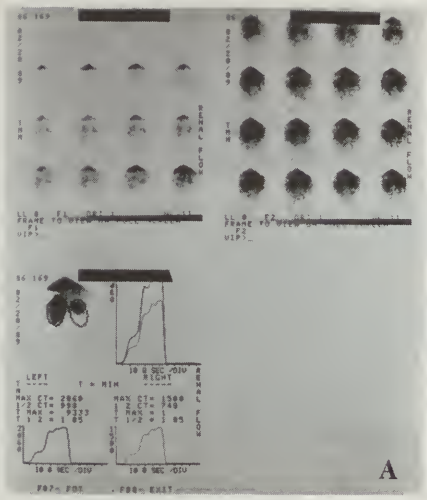


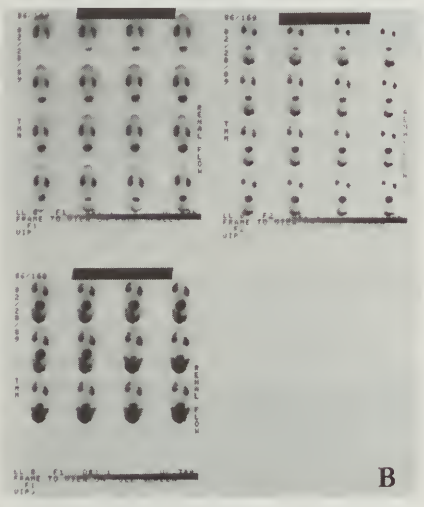
Figures 4A, 4B, and 4C. At two months, a renal flow study was performed following injection of 2.8 mCi of ^{99m}Tc DTPA. Examination of the study demonstrated the kidneys to be normal in size, position, and configuration. Renal perfusion was symmetric. There was delayed transit of the radiopharmaceutical into the pelvicalyceal collecting systems. There was prominence of both lower pole calyces. The bladder was promptly visualized and there was no scan evidence of mechanical obstruction.

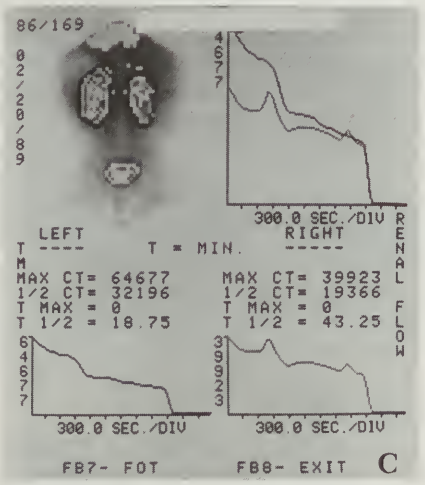
hydronephrosis resolved (Figures 5A, 5B, and 5C).

The second patient was a three-month-old white male. An ultrasound, obtained immediately after birth, demonstrated bilaterally hydronephrosis greater on the right (Figure 6). The patient then was referred to the urology services. A repeat ultrasound at three weeks showed bilateral hydronephrosis greater on the right than the left. He then was referred for a nuclear cystogram and a DPTA renal scan. Following the instillation of 1.0 mCi of ^{99m}Tc into the bladder via a #5 French catheter, sequential scintiphotographs of the bladder and abdomen were obtained following distention of the bladder with 30 cc of normal saline. Examination of the study demonstrated the bladder to be normal in size, position, and configuration. There was no scan evidence of ureterovesical reflux (Figure 7).

Several days later, a renal flow study was obtained after the injection of 3.0 mCi of ^{99m}Tc DTPA. Examination of the study demonstrated the kidneys to be slightly enlarged and normal in position and configuration. There was delayed transit of the radiopharmaceutical into the pelvicalyceal collecting systems bilaterally. This was more marked on the left. The bladder was promptly visualized. There was no scan evidence of







Figures 5A, 5B, and 5C. At six months, a renal flow study was performed following the injection of 3.0 mCi of ^{99m}Tc DTPA. Examination of the study showed the kidneys to be normal in size, position, and configuration. Renal perfusion was symmetric. At approximately 12 minutes, postradiopharmaceutical injection, 10 mg of Lasix® was administered intravenously. There was normal transit of the radiopharmaceutical into the pelvicalyceal collecting systems bilaterally. There was no scan evidence of mechanical obstruction. The asymmetric bilateral hydronephrosis resolved.

mechanical obstruction (Figures 8A, 8B, and 8C).

At 2.5 months, a Lasix® renogram was performed. There was subtle delayed transit of the radiopharmaceutical into the pelvicalyceal collecting system on the left. There was no compromise of renal blood flow. When compared to the previous examinations, there had been interval resolution. There was no scan evidence of mechanical obstruction. This three-month-old infant had minimal resolving unilateral functional nonmechanical hydronephrosis (Figures 9A and 9B).

DISCUSSION

Radionuclide studies are used routinely for the followup and management of patients with known vesicoureteral reflux and frequently are used as a primary evaluation tool in those patients who have predisposition for reflux or urinary tract infection. The technique of radionuclide cystography was introduced in 1959. There are two methods of radionuclide cystography—indirect and direct. Indirect radionuclide cystography does not require catheterization. This is beneficial in a patient who is susceptible to recurrent infections. The principle of radionuclide cystography is the intravenous injection of a radionuclide that completely clears through the kidneys in a short interval. The indirect technique evaluates reflux that primarily is caused by the higher bladder pressure of voiding.[1] The direct technique involves insertion of a catheter with instillation of approximately 1.0 mCi of ^{99m}Tc or sulfur colloid followed by bladder filling with normal saline. This technique of demonstration of reflux scintigraphically with the assistance of computer enhancement is exquisitely sensitive.[2]

Renal scintigraphy is the diagnostic procedure of choice or complementary imaging modality in the workup of the pediatric urology or nephrology patient.[3,4] A number of clinical indications exist for renal scintigraphy including abdominal masses, oliguria, anuria (renal insufficiency, and failure), hypertension, urinary tract infection (UTI), hematuria, search for congenital anomalies, myelomeningocele, prune belly syndrome, trauma, and abnormal perinatal ultra-



Figure 6. Ultrasound immediately postnatal demonstrated bilaterally hydronephrosis greater on the right for the three-month-old infant.

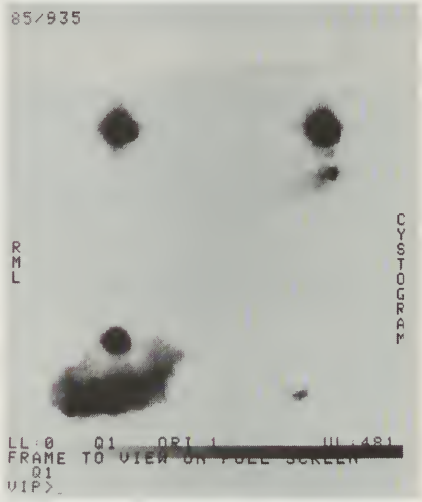
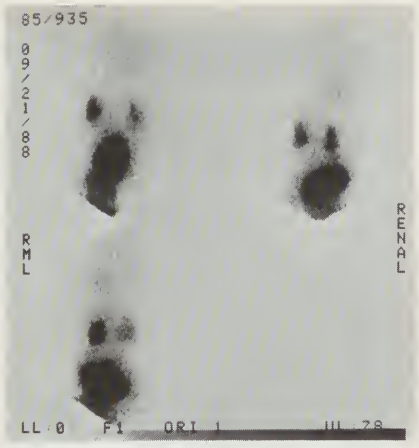
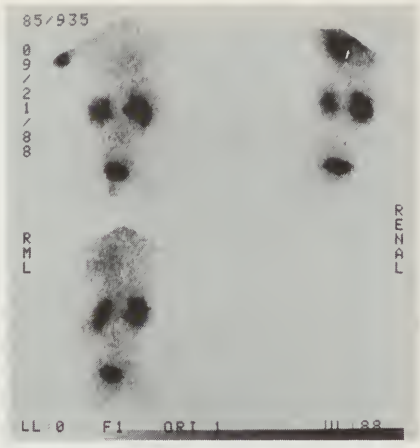


Figure 7. Following the instillation of 1.0 mCi of ^{99m}Tc into the bladder via a #5 French catheter, sequential scintiphotographs of the bladder and abdomen were obtained following distention of the bladder with 30 cc of normal saline. Examination of the study demonstrated the bladder to be normal in size, position, and configuration. There was no scan evidence of ureterovesical reflux.





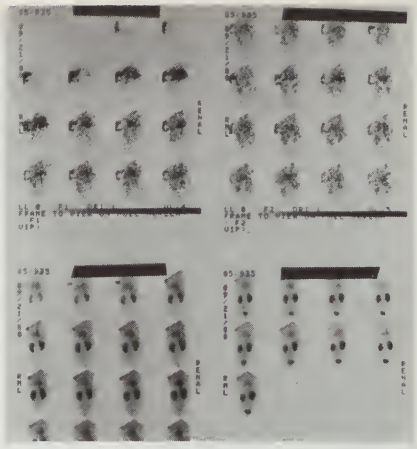
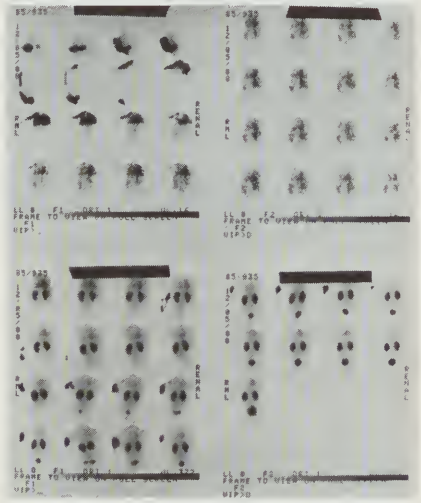
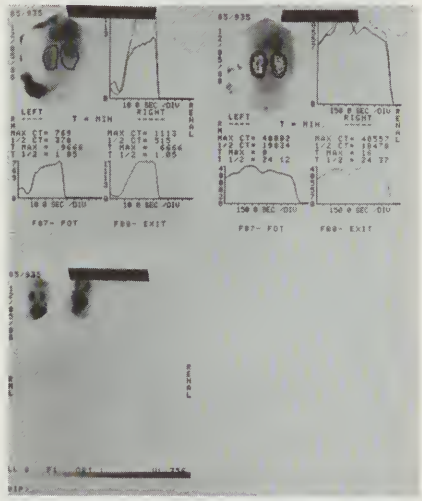


Figure 8. A renal flow study was obtained after the injection of 3.0 mCi of ^{99m}Tc DTPA. Examination of the study demonstrated the kidneys to be slightly enlarged and normal in position and configuration. There was delayed transit of the radiopharmaceutical into the pelvicalyceal collecting systems bilaterally. This was more marked on the left. The bladder was promptly visualized. There was no scan evidence of mechanical obstruction.





Figures 9A and 9B. At 2.5 months, a Lasix® renogram was performed. There was subtle delayed transit of the radiopharmaceutical into the pelvicalyceal collecting system on the left. There was no scan evidence of mechanical obstruction. The patient had minimal resolving unilateral functional nonmechanical hydronephrosis.

sonography findings. The renal scan involves injection of a radionuclide that is predominantly cleared through glomerular filtration (85 percent) ^{99m}Tc DTPA and partially through tubular filtration (15 percent). This relatively simple, noninvasive, low-radiation technique provides information about renal blood flow—symmetry or asymmetry—transit of the radiopharmaceutical into the pelvicalyceal collecting systems, tubular function, functional or mechanical hydronephrosis, and bladder configuration. In addition, renal scintigraphy and the nuclear cystogram are the most sensitive tests for the workup of children with UTI. Since vesicoureteral reflux is the second major predisposing factor of UTI, radionuclide cystography is invaluable in the workup of patients with urinary tract infections. Lasix® renography is particularly valuable in separating mechanical from nonmechanical (functional) hydronephrosis. DTPA is injected intravenously; Lasix® 0.3 mg/kg is injected intravenously when the renal pelvis and calyces are fully visualized (typically 15 to 20 minutes post-tracer injection). Data collection are terminated 15 minutes postdiuretic injection. Regions of interest (ROI) are assigned by computer light pen for kidneys, ureters, and background. ■

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High Posterior Approach to the Internal Jugular Vein

Jeffery Seitzinger, MD
John Pellegrino; MD
Scott Spiro, MD

Thirty-seven patients underwent the high posterior approach to the internal jugular vein with a 97.3 percent success rate. The authors present a simple technique for central venous cannulation. A comparison is made to three standard methods of jugular vein catheterization.

The two most common approaches for central venous catheterization are via the subclavian and internal jugular veins. Serious complications occasionally accompany subclavian venipuncture. Several different approaches to the internal jugular vein have been described as more accessible and less morbid. However, because of patient body habitus and variability in anatomy, the procedure remains less favored among the surgical community.

We present a simple and accurate percutaneous technique, using constant anatomical landmarks—a more attractive alternative to central venous access than previously described.

TECHNIQUE

The patient is placed in the supine position and the head is tilted 30° to the contralateral side. The neck is prepared from the ear lobe to the clavicle.

The mastoid and sternal ends of the clavicle are palpated. A site along the posterior border of the sternocleidomastoid muscle that bisects these two points is selected. The carotid pulsation is identified. This site is infiltrated with 1 percent lidocaine and then a scout syringe and 22 gauge needle is inserted at 90° to the longitudinal axis of the patient's body. The vertical orientation of the needle is level with the floor. The internal jugular vein should be entered within 3 to 4 cm.

If the scout needle does not enter the internal jugular vein on the first attempt, the heel of the syringe should be dropped and the needle directed several degrees above the horizontal plane. The internal jugular vein at this position in the neck lies anterolateral to the carotid artery.

Once the scout is in the vein, it may be left in place and the 14 gauge needle inserted 1 cm cranial to the scout and the needle directed to the tip of the scout. The same vertical orientation should be maintained.

The scout is removed and the remainder of the procedure proceeds as for other guide wire techniques. A routine upright chest x-ray is performed post-insertion.

MATERIALS AND METHODS

Cadaver studies undertaken at the University of Medicine & Dentistry of New Jersey-New Jersey Medical School determined the anatomical principles used as the basis for the high posterior approach to internal jugular cannulation.

Fifteen cadavers were studied. Several anthropometric observations were made: There was great variation in both the length and width of the sternocleidomastoid muscle. The range of length varied from 8 to 14 cm. The width of the muscle varied from 1.25 to 4 cm. It also was noted that the two heads of the muscle varied greatly in regard to the place where they joined to form one main muscle belly. The position of the internal jugular vein varied in its position between the two heads of the sternomastoid muscle.

When the head of each cadaver was positioned at an angle of 30° from the vertical, the internal jugular vein was apparent along the posterior border of the sternomastoid muscle at a point that bisected the length of the sternomastoid muscle from its origin at the mastoid process and its insertion at the sternal angle. This relationship held true in all 15 cadavers tested by stereotactic means.

These facts formed the basis for the approach developed at our hospital for cannulation of the internal jugular vein.

RESULTS

Thirty-seven patients underwent this procedure from January 1987 through August 1989. In one patient, the approach was

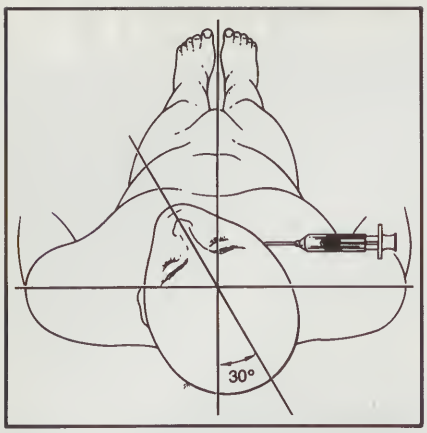


Figure 1. Craniocaudal view. Scout needle localization of the internal jugular vein.

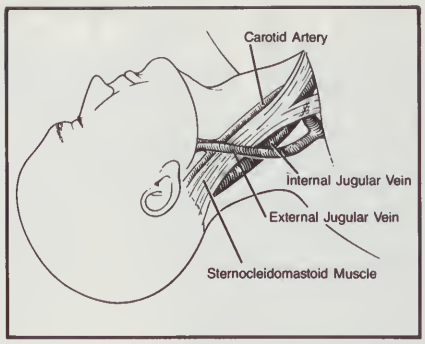


Figure 2. Schematic neck anatomy reveals the close proximity of the internal jugular vein to the carotid artery and posterior surface of the sternocleidomastoid muscle. Illustration by Beth Willert.

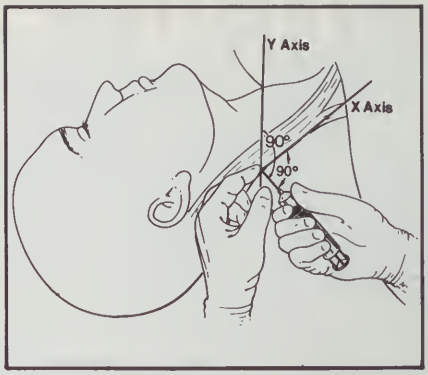


Figure 3. Surgeon positioned lateral to the patient. The needle is inserted at a right angle to the longitudinal axis of the patient's body. Illustration by Beth Willert.

unsuccessful because the vein was not located. In the remaining 36 patients, the vein was entered in less than 4 cm. Complications included a single carotid puncture, using the scout needle, that was handled by removal of the needle and firm pressure for ten minutes. No undue sequellae occurred. A single instance of the guide wire passing cephalad occurred. This was corrected by removal of the guide wire and rethreading. No undue sequellae occurred. There were no instances of hematoma, pneumothorax, or other complications.

DISCUSSION

Central venous cannulation provides direct access to the venous circulation for emergency rapid fluid resuscitation, measurement of central venous pressure, right heart catheterization, or hyperalimentation.

The two major disadvantages associated with subclavian catheterization are pneumothorax and hemothorax. These complications are less likely with internal jugular cannulation.

There are three approaches to the internal jugular vein:

Posterior Approach.[1-2] This approach introduces the needle under the sternocleidomastoid at the junction of the middle and lower thirds of the posterior border and aiming caudally and centrally toward the suprasternal notch.[3] The vein then is entered within 5 to 7 cm.

Central Approach.[4,5] The needle is inserted at the center of the triangle bound by the two lower heads of the sternocleidomastoid muscle and clavicle and directed parallel to the medial border of the clavicular head of the sternocleidomastoid toward the ipsilateral nipple.[3]

Anterior Approach.[6] The carotid artery is retracted medially from the anterior border of the sternocleidomastoid. The needle is inserted at the midpoint of this border and directed toward the ipsilateral nipple.

Specific complications of these three approaches include pneumothorax, neural injury, thoracic duct injury, hematoma, tenderness, and catheter malposition.[3] Hemopericardium also has been reported.[7] Using the high posterior approach, none of these complications was encountered. The main complication of our approach is puncture of the carotid artery.

CONCLUSION

Pneumothorax and hemopericardium are potentially life-threatening complications of other approaches to central venous cannulation. Using our approach, the needle is inserted sufficiently craniad to avoid pleural or mediastinal puncture. Moreover, this approach causes substantially less morbidity and little opportunity for serious complications. Additionally, this technique is anatomically based and easier to master. The high posterior approach is a quick, efficient, and relatively safe alternative method of central venous catheterization. ■

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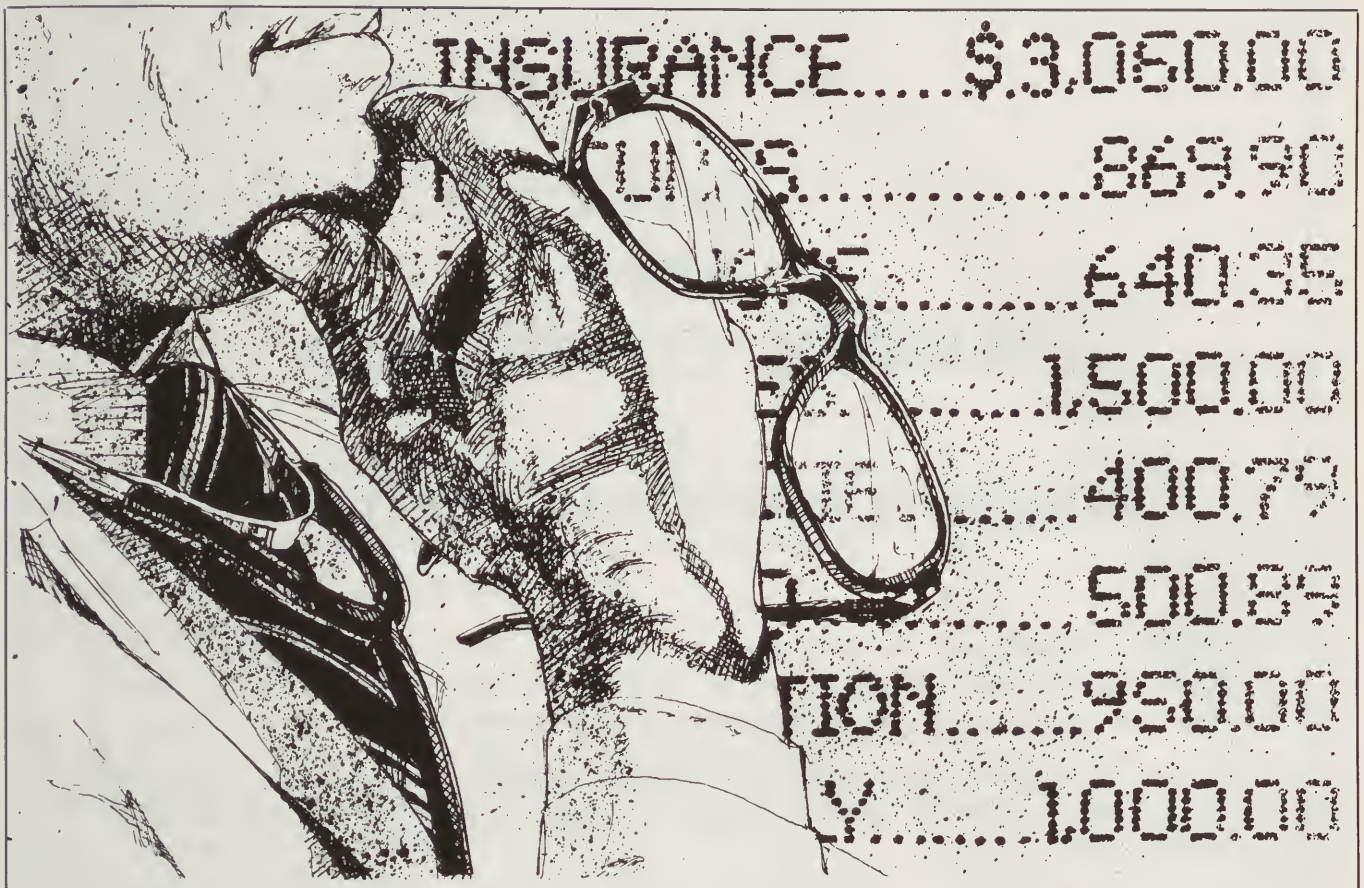
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Part I: Basic Approach to Health Screening

David E. Swee, MD
Laura Micek-Galinat, MD, MPH

A variety of recommendations exists regarding the screening of disease in asymptomatic individuals. In the first of a two-part series, the authors provide a basic approach to health screening, including historical background, barriers, and criteria.

What is health screening? Whom should physicians screen and how often? What are good screening tests? In Part I, we will address these questions and outline a rational approach to assessing screening interventions. In Part II, we will raise specific questions that should be answered when reviewing particular interventions; we will apply this approach to some of the current health screening controversies.

In the last 20 years, we have seen an outpouring of research addressing the questions of health screening, questions that previously had been de-emphasized in favor of the interventionist strategies of traditional tertiary care medicine. However, the basic questions have remained. Since the turn of the century, patients have come to physicians for reassurance regarding their health and for advice to maintain or improve it. This paper will address a method of answering these questions, taking into account the public health research as well as the needs of individual patients and their physicians. Many of the questions remain controversial and our recommendations are guidelines. A host of recommendations are available to those interested.[1-11]

HISTORICAL CONTEXT

At the turn of the century, the new wave of immigrants brought to this country some European traditions of health care, including the Nordic fitness belief in an annual visit to the physician for general health care concerns. By the 1920s, the AMA, various other members of the public health community, and the government were urging the public to see a physician on a yearly basis; such a campaign was launched by the AMA in 1922, hoping that visits would lead to the improved general health of the population by discovering and caring for diseases.

Even then, such recommendations were considered more theoretical and idealistic than practical. There have never been enough physicians in the United States to provide yearly physicals. Even primary care practitioners, seeing 2,500 patients per year, could not provide annual physicals without interfering with other medical care.

After World War II, the modernization and industrialization of health care included a number of large-scale screening efforts. The results of multifaceted screening in some of the larger group practices and HMOs in California proved to be a disappointment at attempting to improve the health of the screened population. Many public health experts believed, however, that for subpopulations a careful selection of tests would have helped. Screening throughout the 1950s and 1960s remained the purview of the public health sector. In the 1970s, four major publications led to a reawakened clarification of the role of the private individual practitioner's role in screening.

Until the 1970s most population screening was done on persons clinically well but who could have had a disease, e.g. hypertension, found on one pass screening with a simple yes or no answer. The plan was to refer patients with positive results to their own physicians. It was recognized early that screening at the individual physician level would be more of a case finding effort where patients would be seen with known diseases, usually chronic in nature. In contrast to the population-based screening of patients, the odds were that any individual patient seen in the office would have a low likelihood of unrecognized disease regardless of the percentage of total disease in the population as a whole. Also, positive results would prompt serial workups and

multifactorial investigations, so that the consequences of a single positive test could be a host of further interventions.

In the mid-1970s, Frame and Carlson proposed adapting public health criteria to the assessment of the yearly physical.[1] In particular, they utilized the concept that specific criteria of worthiness of a screening test could be applied to individual testing interventions. A testing intervention then would be accepted or rejected, depending if it met the standards. In other words, instead of judging the criteria of the worthiness of the illness, the worthiness of the test would be judged.

Breslow and Somers followed this with a recommendation of a broad-based screening program that highlighted Frame and Carlson's work.[2] They proposed a program that was age specific and across the life span. While not agreeing with all the specific recommendations of Frame and Carlson, there was a fairly high degree of concordance. Closely following these two works came the important publication of the Canadian Task Force on the Periodic Health Examination that assessed the effectiveness of over 70 screening interventions.[3] They graded interventions on a five-point scale from totally indicated and totally supported by literature through totally not indicated and totally rejected by literature. Since the Task Force was making public health recommendations for Canadians as a whole, some of its recommendations were more sweeping and global than those of Frame and Carlson or Breslow and Somers. Finally, the American Cancer Society, at the end of the decade, reported its recommendations for health screening of cancer problems that, for the most part, were generally consistent with the logic of the previous sets of recommendations.[4]

These formative works reflect the major thinking in academic preventive medicine over the last two decades that led to a remarkable surge of interest in the area of screening.[5-11] At the end of the 1980s, the United States Preventive Services Task Force published its report of recommendations for the American public.[11] The recommendations of this Task Force changed the recommendations of the previous authors only as a result of the improved knowledge in health screening, and not because of any substantive change in Frame and Carlson's criteria.

However, there always have been difficulties in translating Frame and Carlson's criteria to the level of the private practitioner.

BARRIERS TO SCREENING

There are a number of obvious barriers to screening:

1. Interest. While one would think all patients are fantastically interested in their level of health, some patients are reluctant to be tested in certain ways or to discover unpleasant news, so it is very difficult to get either patients or physicians to comply with well-accepted screening recommendations.[12-23]

2. Financial. While the patient may have a financial stake in discovering disease, physicians have little to gain in the current insurance climate. Even in capitated systems, that may reward physicians for having healthy patients, physicians who discover diseases early, benefit the insurance company more than themselves under a prepaid system. Physicians that perform prevention activities in this system are to be lauded, but certainly this does not demonstrate good fiscal sense.

3. Accessibility. Accessibility to health care is an ongoing problem in this nation with a host of patients who cannot afford health screening. Accessible health care, however, is compromised not only by economics but also by distance, geography, and understanding.

4. Language. Language difficulties in a non-English speaking patient, can be a major barrier. In the normal heterogeneous setting, a physician will see a patient sometime during his day that does not fluently speak the same language. In addition, since screening often involves concepts that are complicated with a prolonged explanation, even for those patients that speak the physician's native tongue, language becomes a major barrier.

5. Results. The low yield of positive returns, while gratifying to patients, tends to frustrate physician participation and produce yet another barrier. It is one thing to treat the acute ill, to save lives, and to feel proud of one's performance. On the other hand, to see 10 to 15 patients "only" to reassure them that they are well and to feel good about that requires a very different understanding and set of goals. We need to continue the search for ways of improving physician compliance with screening recommendations.[24-27]

PRINCIPLES/CRITERIA FOR SCREENING

All criteria for screening have a certain artificiality and need to be taken in the context of the individual patient or practitioner and a host of external variables. However, we believe that the following three major areas of concern are most important: characteristics of the disease; characteristics of the population to be screened; and characteristics of the test (Table 1).

In terms of characteristics of the disease, the disease must be significant in terms of morbidity and/or mortality. Few practitioners or patients are interested in discovering conditions of little consequence. However, screening in the individual office is vastly different from that in public health programs. There may be a situation where a patient's anxiety about a condition, regardless of its nature, may prompt the physician to search for the disease.

Regional variations also may lead a physician to screen for conditions not given equal weight at the national level; a current example is human immunodeficiency virus infection, among the top ten causes of all deaths in New Jersey and the number one cause of death in the 25-to-44-year-old age group (Table 2).

An important point made by Frame and Carlson and others is the difficulty screening for diseases that do not have a prolonged asymptomatic phase. This single criteria often is ignored when physicians argue for such screening tests as the complete blood count or serum electrolytes. Many familiar diseases occur rapidly and screening for them with current testing methodologies is inappropriate.

The availability of treatment is a controversial aspect of screening. Some would argue that knowledge of a disease is important enough in and of itself, even if no treatment is available. Others note that such knowledge often is more harmful than helpful. The whole controversy in screening for Huntington's chorea is a classic case. It often is hard for physicians to accept this negative aspect of screening. Most physicians and patients feel a person is better left unaware about diseases with no treatment. On the other hand, it behooves a physician to be careful with a patient who claims not to want to know conditions for which no treatment is available. Certainly, the physician must make every effort to ensure that the patient has understood the advantages and disadvantages of any screening procedure.

In addition to characteristics of the disease, there are characteristics of the population that impact on a physician's choice of screening tests including the high prevalence of the disease in a particular population, the degree of acceptance of the test in that population, and the ability of individuals to comply with the testing, including reporting test results, if it involves patient participation.

The characteristics of a particular population, as well as the disease itself, determine the prevalence of disease within that population. The prevalence of gonorrhea and chlamydia in the subpopulation that attends sexually transmitted disease (STD) clinics is different from that in the population seen in a family physician's office. In that example cited, screening for gonorrhea in the STD clinic might be entirely appropriate, while it probably is not appropriate in a family physician's office on a routine basis; even if the test is equally sensitive and specific, the positive predictive value will be much lower in a family physician's office.

Aside from the prevalence within a particular population, populations will vary in their acceptance of a test. It is fruitless to recommend a test, e.g. sigmoidoscopy, if patients are not willing to submit to the procedure. With the advent of flexible sigmoidoscopy, attitudes changed; there was new acceptance of an uncomfortable test. However, people tend to resist the higher fees associated with such preventive activities—another factor in the degree of screening acceptance.

An important criterion proposed by many authors is the ability of patients to comply with the testing procedures, including the ability to report results. This is important in a home screening device such as stool hemoccult testing. Also, many screenings consist of questions asked during the examination, or formal questionnaires. It is especially important for simple and clear language to be used. An example of a population where this criterion would not hold is a nursing home population; patient understanding is unreliable. Similarly, when patients are hesitant to report results, e.g. migrant workers delaying or not reporting spitting up blood because of fear of loss of occupation, screening in that context will change dramatically.

Finally, we must understand the characteristics of the test itself. A cause of particular confusion between the private care setting and the public health sector is the differing uses of sensitivity and specificity. From the public health viewpoint, the most important criterion for a screening test is high sensitivity. If a physician is screening a large population of citizens and wants to identify patients with a particular condition, e.g. hypertension, it is important to have

Table 1. *Criteria for screening examinations.*

Characteristics of the Disease

- Significant morbidity and/or mortality
- Prolonged asymptomatic phase
- Effective treatment available

Characteristics of the Population

- High prevalence
- Acceptance of the test
- Ability to comply/report

Characteristics of the Test

- Good sensitivity and specificity
- Validity and reliability
- Cost effectiveness

Table 2. *Top ten causes of resident deaths in New Jersey in 1988.**

1. Heart diseases
2. Malignant neoplasms
3. Cerebrovascular diseases
4. Pneumonia and influenza
5. Accidents
6. Diabetes mellitus
7. Septicemia
8. Human immunodeficiency virus infection
9. Chronic liver disease
10. Nephritis, nephrotic syndrome, and nephrosis

*Source: Phyllis Spych, Center for Health Statistics, New Jersey State Department of Health

high sensitivity for that condition, even if it leads the physician to collect a large number of patients who are falsely positive. However, for the individual practitioner, the more important criterion is specificity, the ability of a test to accurately identify those without the disease. Since it is unlikely for any individual patient to have the condition, it is more important to clearly identify those without the disease.

The consequences of a false positive can be severe. A dramatic example of this is HIV testing. Recent reports of routine HIV testing have led to the concerns over the number of false positives. Regardless of how few, inappropriate diagnosis of AIDS can have devastating consequences for individuals. Society may be willing to pay the price of such a consequence, but it has to beware of the true costs. We cannot just do a second test to eliminate the false positives, resulting in a never-ending series of tests, and a never-ending series of false positives created from that test. In the end, there always will be a group of patients for whom false positives occur. Of course the more one tries to eliminate the false positives the lower becomes one's sensitivity.

Validity and reliability are other concepts rarely discussed in the medical literature. These concepts more often are discussed in the context of mental health screening, where questionnaires and intelligence quotient (IQ) testing devices have been used since the turn of the century. These instruments more often are thought of as tools for clinical diagnoses than screening tests. However, they have been widely disseminated and used in many screening contexts, e.g. in an initial job interview, as a screening device to "weed out the crazies."

Validity applies to the degree of reality by which the test claims to achieve its results. That is, if a test is identifying people who are scared of heights, does it actually find people who are scared of heights? Validity, thus, is another way of discussing sensitivity and specificity. An important example in health screening is the use of hemoccult testing as a screen for colorectal cancer. Given that the test is a test for blood in the stool, the validity of any one positive result in terms of neoplastic disease is questionable. And yet, such a result routinely creates an expensive and somewhat dangerous workup.

Reliability—the ability of a test to remain consistent over time in its administration—is important to both the bench laboratory and the psychology couch, although rarely discussed in the health screening literature. The question, "If we test you today, will we get the same results tomorrow?" cannot be always answered positively with even common tests, such as cholesterol screening. Not only are there factors such as the time of day, but normal variations and changes in the methodology of the tester and the test taker that can produce problems with reliability. Again, a good example is hemoccult testing, where patient characteristics that might make reliability unacceptable include the inability of patients to correctly follow testing diets and perform the necessary stool collections in a correct and timely fashion. A better designed test would be able to overcome some of that liability, but to date, none has been developed.

The last characteristic of the test to be considered is cost effectiveness. This term refers to the value placed on a test by any group of individuals. If money is no object, cost effectiveness is of no concern; however, in real world modern medicine, money is a reality and each test has a price tag. This includes not only the actual cost of the performance of the test, but also the costs to work up the false positives, and the differential in cost between the care of those found early and those found late. (One of the more interesting results of screening programs can be the cost caused by such apparently benign procedures as the screening itself. One study demonstrated a significant increase in sick days with a group testing positive for hypertension as compared to another group who also had hypertension but knew in advance of their condition.[28])

Many of the ethical arguments about health screening concern the differing values placed on prevention. Although it often has been claimed that screening saves money because of assumptions about the cost-benefits of earlier treatment, this has not always been proved.[29] Moreover, there is no moral imperative that prevention is the cheapest modality. We may consciously choose to act in a preventive fashion even if it is more costly, particularly if we take into account other values not usually calculated in traditional analyses of cost benefits, such as the improved chance for emotional adjustment to a disease if found earlier or the more subtle claim of an improved dignity of the person given an earlier discovery of the condition.

Many of the tests used in screenings are not actually blood tests or other laboratory procedures: they are simple interventions such as asking a patient if they smoke (a "test" with remarkably high sensitivity and almost 100 percent specificity, i.e. very few people purposely lie and say that they do smoke when they actually do not smoke) and many mental health assessments. For example, mental status tests are not only used diagnostically, but also are used for screening—such as the prevalence of depression among the patients in the waiting room of the family physician's office.

CONCLUSIONS

For arbitrary reasons we have chosen not to address screening in pediatric and adolescent medicine, nor in geriatric medicine. One aspect that would make such a screening discussion more difficult is that much of the research in the last 20 years has been on middle-aged, adult populations. Much less is known about the geriatric population, for instance. This is partly because of the individual complex nature of this patient population (with problems such as inability to comply or report, and differentiating between discovering known disease versus unknown disease).[30-34]

In terms of pediatric screening, suffice it to say that while criteria have been known for a long time it has been difficult to apply them to a basically healthy population where the disease prevalence is even lower. Thus, much of the prevention screening focuses on the discovery and reinforcement of healthy behaviors (use of seatbelts). Whether any of these interventions, or even routine examinations by physicians, are actually effective remains controversial.[35-37]

A particular area of controversy is seen in some activities outside a physician's office, such as screening for scoliosis or developmental disabilities. In both, mass screening programs have not been proved to be effective despite their continued popularity. Scoliosis treatment remains controversial and the few recommendations that have evolved have not supported mass scoliosis screening.[38] Similarly, misidentification of children with "disabilities" by mass screening programs, if anything, have labeled them in negative fashion so that they have ended up worse off than before the screening.[39]

Finally, we will not discuss screening for mental health problems. The context in which screening occurs has a great deal to do with the effectiveness of the test as well as the appropriateness of the intervention. An emergency room might be a logical place for such a screen, but is used more often as a diagnostic tool. Physician offices have been known to have a high rate of mental disorders, including depression, alcoholism, and substance abuse; that physicians should look for these is not controversial. In this area, the controversies surround the particular devices to be used and what to do with the results of the screenings from this group of patients.[7,11,40]

Part II will appear in the next issue of *NEW JERSEY MEDICINE*. ■

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Drs. Swee and Micek-Galinat are affiliated with the Department of Family Medicine, UMDNJ. The article was submitted in January 1991 and accepted in March 1991. Part II will appear in the next issue. Requests for reprints may be addressed to Dr. Swee, UMDNJ-Robert Wood Johnson Medical School, One Robert Wood Johnson Place, New Brunswick, NJ 08903-0019.

MSNJ Golden Merit Award Recipients

At ceremonies held on April 29, 1991, at the Trump Taj Mahal Casino/Resort, Atlantic City, the following physicians received the Medical Society of New Jersey's Golden Merit Award indicating they held the degree of doctor of medicine for 50 years.

Atlantic County

Albert John Battaglia, MD ..... Hahnemann '41
H. Emerson Burkhardt, MD ..... Temple '41

Bergen County

Dino Daniel Calabrese, MD ..... Marquette '41
Peter James Dulligan, MD ..... Long Island '41
Joseph J. Geller, MD ..... New York University '41
Stanley E. Prentice, MD ..... Columbia '41
Francis Rosner, MD ..... New York University '41
Frederick Joseph Wertz, MD ..... Georgetown '41

Burlington County

John Whitall Nicholson, III, MD ..... Pennsylvania '41

Camden County

George E. Covintree, MD ..... Hahnemann '41
Joseph Mario De Luca, MD ..... Hahnemann '41
Vincent S. Palmisano, MD ..... Jefferson '41

Cape May County

Anatoly Borisow, MD ..... Saratov '41
Paul Herschel Pettit, MD ..... Jefferson '41
Wayne Holden Stewart, MD ..... Michigan '41

Cumberland County

Pasquale Arthur Ruggieri, MD ..... New York University '41

Essex County

Robert Hallett Areson, MD ..... Yale '41
Louis Vincent Belott, MD ..... Cornell '41
George Ludwig Benz, MD ..... Georgetown '41
Lawrence Frederick Burnett, MD ..... Jefferson '41
Saul I. Firtel, MD ..... New York Medical '41
Gerald E. Fonda, MD ..... New York University '41
Thomas Vincent Judge, MD ..... Columbia '41
Leonard William Leeds, MD ..... Dalhousie '41
Harold E. Lippman, MD ..... Howard '41
Max M. Novich, MD ..... Louisville '41
Sidney Eugene Pendexter, Jr, MD ..... Columbia '41
Max Nathaniel Pusin, MD ..... Minnesota '41
Sidney Rubin, MD ..... Lausanne '41
Paul James Russomanno, MD ..... Loyola '41
George Gilbert Salmon, Jr, MD ..... Hahnemann '41
George Stefaniwsky, MD ..... Charles '41
C. Richard Weinberg, MD ..... Wayne '41
Irwin Warren Winfield, MD ..... New York University '41
Nathan Zukerberg, MD ..... Lausanne '41

Hudson County

Mario John Albini, MD ..... Loyola '41
Herman L. Aronoff, MD ..... New York University '41
Charles F. Baldini, Jr, MD ..... Med. College of Virginia '41
Charles Kenneth Brauer, MD ..... Hahnemann '41
Salvatore Joseph Detrano, MD ..... New York Medical '41
Morris Schapiro, MD ..... Tulane '41

Mercer County

Helen Elizabeth Daniells, MD ..... Cornell '41
Frank Rathauser, MD ..... New York University '41
Bernard M. Schnur, MD ..... Tulane '41
J. Minor Sullivan, III, MD ..... Meharry '41
Blair N. Vine, MD ..... Columbia '41
John Sergeant Wise, MD ..... Pennsylvania '41

Middlesex County

Noah Barysh, MD ..... Rush '33
Milton Bernard Brown, MD ..... New York Medical '41
Richard J. Cross, MD ..... Columbia '41
Norval F. Kemp, MD ..... Maryland '41

Morris County

Sam Clark Atkinson, MD ..... Tulane '41
Dexter Barnes Blake, MD ..... Columbia '41
Morris Dirdack, MD* ..... Anderson '41



Golden Merit Award

John T. Reilly, MD
..... Temple '41
Seymour S. Van-Wiemokly, MD
..... St. Louis '41

Passaic County

Jerome Brawer, MD
..... George Washington '41
Kyu Yong Lee, MD
..... Seoul '41
Anthony J. Santoro, MD
..... Georgetown '41
Julius Milton Shier, MD
..... Washington, St. Louis '41
Igor Sinchugov, MD
..... Rostov '41

Somerset County

Harry Abramson, MD
..... Louisiana '41
Homer Elms Cook, MD
..... Hahnemann '41

Sussex County

Harold Vinton Coes, MD
..... Columbia '41

Union County

John Charles Bentley, MD
..... Tufts '41
Mildred Thompson Bohne, MD
..... Cornell '41
Delma Wells Caldwell, MD
..... Rush '41
Edward Myles Coe, MD
..... New York Medical '41
Elizabeth Conover, MD
..... Cornell '41
Lloyd A. Dallam, MD
..... Meharry '41
Herbert William Diefendorf, MD
..... Yale '41
Herbert I. Puller, MD
..... Creighton, '41
John V. Triolo, MD
..... Long Island '41
Gene Albert Zirpolo, MD
..... St. Louis '41

Warren County

Charles Phelps Barnett, MD
..... Maryland '41

*Awarded posthumously.

The Medical Society
of New Jersey
extends its congratulations to

Vincent A. Maressa, JD

Executive Director

1991 Citizen's Award

The Academy of Medicine of New Jersey

Members and staff of the Medical Society of New Jersey congratulate Vincent A. Maressa upon receiving the 1991 Citizen's Award from the Academy of Medicine of New Jersey. This select honor was granted on May 29, 1991, at the Academy's Annual Awards Dinner in Short Hills.

The Citizen's Award is presented annually to that citizen or group of citizens of New Jersey who merit recognition by the Academy for distinguished service in the interest of the health and welfare of the community at large.

DOCTORS' NOTEBOOK

TRUSTEES' MINUTES

A regular meeting of the Board of Trustees was held on April 7, 1991, at the executive offices in Lawrenceville. Detailed minutes are on file with the secretary of your county society. A summary of significant actions follows:

President's Report . . . Noted that a clear and reasoned argument to legislators and a public education effort will continue concerning A-4367 (mandatory assignment).

Exec. Director's Report . . .

1. MSNJ Membership . . . Noted that an improving trend in dues-paying members is developing.

2. Financial Statements . . . Reviewed and approved the financial statements for the period ending March 31, 1991.

3. Litigation . . . Noted the following: the Society is appealing the adverse ruling on the $100 licensing fee in the no-fault case; an adverse opinion on the medical malpractice surcharge case has been rendered in the Appellate Division and petitions for certification to the Supreme Court have been filed; and MSNJ is opposing the authorization of physician assistants.

4. State Board of Medical Examiners Regulations . . . Noted the following: MSNJ will develop a position consistent with submitted suggestions and comments regarding the proposed rules on business practices; and, the registration fee for a physician medical license will increase to $220 for a two-year period.

5. Legislation . . . Noted the following: the Assembly Appropriations Committee continues its consideration of the mandatory assignment bill (A-4367); the health care reform bill (S-3251) has been scheduled for an April vote in the Senate; and A-4585 that provides nurse practitioners, nurse midwives, and clinical nurse specialists with prescriptive powers appropriate to their specialty areas will be considered.

UMDNJ Report . . . Heard from Stanley S. Bergen, Jr, MD, concerning recommended tuition increases and mandatory AIDS testing for patients. Noted that the issue of mandatory HIV testing was referred to MSNJ's Task Force on AIDS for study and report back to the Board.

NJ Hospital Association . . . Heard from Louis P. Scibetta concerning: a) NJHA proposal that the uncompensated care bill be expanded to include maintaining hospitals' full financial requirements as mandated by state law, temporarily re-establishing the Uncompensated Care Trust Fund, promoting reforms that would reduce uncompensated care, repealing obsolete regulations, and using a portion of the Fund to balance the finance reforms; b) a $300,000 HRET grant from Johnson & Johnson for the promulgation of total quality management principles to the state's 118 hospitals; and c) brain death determination bill.

Committee on Biomedical Ethics . . . Voted to refer the following recommendation to legal counsel:

That correspondence be addressed to the commissioner of the Department of Health indicating that the guidelines do not reflect New Jersey law and should be revised accordingly and that the Committee on Biomedical Ethics be notified of any proposed regulations relating to biomedical ethics issues and given an opportunity to review and respond to them before they are finalized.

Committee on Finance and Budget . . . Approved the following recommendations:

That the budget for the fiscal year beginning June 1, 1991, and ending May 31, 1992, in the amount of $4,264,000 with $2,546,000 to be raised through member assessments be adopted.

That the 1992 assessment be set at $350 per regular dues-paying member. (No change from prior year.)

That the 1992 assessment be set at $60 per member for affiliate members (no longer practicing in New Jersey). (No change from prior year.)

That the 1992 assessment for associate members (interns/residents nonlicensed in New Jersey) and licensed residents, provided the individual is in a residency program entered upon within a reasonable time after his graduation from medical school, be set at $25. (No change from prior year.)

That the 1992 assessment be set at $10 per student for medical students. (No change from prior year.)

Unfinished Business . . .

1. Good Samaritan Immunity . . . Noted that legal counsel is proceeding to seek an amendment that extends immunity when physicians are providing uncompensated care and their conduct comes within the standard of good faith action.

2. MSNJ Judicial Mechanism . . . Accepted the recommendation of the Judicial Council and that county medical societies contact Mr. Maressa if they are interested in legal representation.

3. Committee on Senior Citizens and Senior Citizens Task Force . . . Noted that Dr. Riggs will restructure and assign new directives to these groups.

New Business . . . Noted that MSNJ will oppose a rule proposal concerning physical therapists and the right to perform electromyography. □

Researchers find cells that stimulate production of vital hormone. Scientists have identified the specific cells in the brain that stimulate the production of a vital brain-survival hormone called nerve growth factor (NGF), a finding that could ultimately lead to new treatments for Alzheimer's disease.

The researchers at UMDNJ–Robert Wood Johnson Medical School, Piscataway, found that when certain cells, called astrocytes, are actively growing, they turn on the gene that produces NGF. NGF controls the growth and survival of neurons, exceptionally elongated cells in the brain that control the body's communications network. Astrocytes are one of three types of glia, the cells that surround the neurons and occupy the spaces between them. The researchers now are studying how the astrocytes signal the NGF gene to turn on. Understanding how to switch on NGF may lead to a treatment for Alzheimer's disease. The research is being led by Dr. Ira Black, chairman of the school's Department of Neuroscience and Cell Biology.

Dean Humphrey returns to duty to counsel soldiers. Dr. Frederick J. Humphrey II, dean of UMDNJ–School of Osteopathic Medicine, has been called to active duty in Washington, DC, to help facilitate the delivery of mental health care to soldiers, including those returning from the Persian Gulf.

Dr. Humphrey has become Colonel Humphrey, consultant in the Office of the Army Surgeon General.

Army honors Dr. Hymowitz for anti-smoking program. For his leadership in training Army physicians to help soldiers stop smoking, Dr. Norman Hymowitz of UMDNJ–New Jersey Medical School, Newark, has been awarded the Army's Outstanding Civilian Service Medal.

Dr. Hymowitz, professor of clinical psychiatry, helped develop smoking cessation training procedures for health care providers as part of the Army's health promotion programs. The citation accompanying the medal states that it was awarded "for exceptional meritorious service through the enhancement of military medicine and soldier readiness."

The award, signed by Frank F. Ledford, Jr, the Army's surgeon general, noted that Dr. Hymowitz's "impeccable knowledge and leadership influenced medical progress, military policy, and the readiness of our Armed Forces on a worldwide basis. He played a critical role in the structuring of our medical interventions."

Dr. Slaughter named to lead Minority Health Institute. Dr. Billie Slaughter has been appointed executive director of UMDNJ's Minority Health Institute in New Brunswick. She had been director of educational resources at the UMDNJ–School of Osteopathic Medicine. The Institute will identify and analyze risk factors and recommend interventions to narrow the disparities between rates of death and illness among New Jersey's general population and the state's minorities, poor, and other medically underserved groups. The Institute also will provide education and support to medical professionals, government agencies, and the community on measures that may reduce the rate of preventable disease and death among minorities and underprivileged in New Jersey.

Military medicine exhibit opens at UMDNJ–Smith Library. A surgeon's account of treating patients with gunshot wounds in 1550 and photographs of a Newark physician in Nagasaki, Japan, after the atomic bomb was dropped are part of an exhibit of historic military medicine on display at UMDNJ–Smith Library of the Health Sciences. The exhibit, "Military Medicine 1517-1973," features 20 rare books and several photographs, all depicting medical advances made during times of war. It includes the first illustration of a battlefield amputation. On display through mid-September, the exhibit can be viewed in the library's Exhibition Gallery, 30 Twelfth Avenue, Newark. The library is open to the public daily from 9 AM to 6 PM. □ Stanley S. Bergen, Jr, MD

ARE YOU MOVING?

If so, please send a change of address to *NEW JERSEY MEDICINE,* Medical Society of New Jersey, Two Princess Road, Lawrenceville, NJ 08648, at least six weeks before you move.

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MSNJ AUXILIARY

At the Annual Meeting of the Medical Society of New Jersey Auxiliary, Jean Carroll Taboada was installed as the organization's 65th president. She is the wife of Alberto Taboada, MD, an anesthesiologist.

Mrs. Taboada was born and raised in Long Branch. She is a twin with seven brothers and four sisters. After graduating from Long Branch High School, Jean was awarded a full nursing scholarship from the Monmouth County Medical Society Auxiliary. Upon completing her training at Monmouth Memorial Hospital School of Nursing, she worked in the operating room at Monmouth Memorial Hospital where she met her future husband.

Dr. and Mrs. Taboada now reside in Bricktown, Ocean County. They have five grown children and one granddaughter. Her three sons are mechanical engineers; her daughters are businesswomen. Jean is a sailing enthusiast and her children are accomplished sailors. As a member of the Metedeconk River Yacht Club, she received the sportsmanship award voted by the sailors and given annually to an individual who has contributed greatly to the sport of sailing. Mrs. Taboada also has served as chairman of the Junior Committee overseeing the sailing, swimming, and social activities of the club juniors. In addition, she was president of the Yacht Club's women's group, "Mermates," for two years and served on the club's executive board.



Mrs. Jean Taboada

Her other activities include membership in the Strand Theater League, a fundraising group for the Ocean County Center for the Arts; she also served as coeditor of the League's cookbook, "Stranded in the Kitchen." Jean has been involved in the PTA and the Barnegat Windjammers (a chapter of Questors) serving as recording secretary.

As a member of the Ocean County Medical Society Auxiliary, Jean served as raffle chairman, scholarship chairman, luncheon chairman, AMA-ERF chairman, newsletter editor, and president. On the state level, she has been AMA-ERF chairman, membership chairman, recording secretary, director (three years), member of the Long-Range Planning Committee, vice-president, and president-elect.

LYME DISEASE

Lyme disease is a major public health problem in New Jersey. First described in the mid 1970s, Lyme disease now affects people across our state, with problems related to active disease, and anxiety about possible inadequate therapy, the available radical forms of therapy, improper diagnosis (both over- and under-diagnosis), risk of progression to late manifestations, risk to pregnancy, and risk of exposure. Many of these topics have been the subject of lectures given at

UPCOMING SPECIAL ISSUES

Addiction

Guest Editor:
George Mellendick, MD, MPH

Sports Medicine

Guest Editor:
Paul J. Hirsch, MD

many venues across the state and at national and international conferences and of articles in the major medical journals. However, physicians and the public remain confused about these and other aspects of Lyme disease. Much appears in the lay press that either is confused or distorted, or incorrect. Many claims are publicized with little or no scientific proof. Apprehension has given rise to a parallel set of "truths" that often guide patients and physicians in improper directions. We, in New Jersey, are not alone in being overwhelmed by the avalanche of information about Lyme disease.

Suggestions for articles on Lyme disease and the organism that causes it, *Borrelia burgdorferi*, include: a review of clinical manifestations of Lyme disease; the diagnostic tests available, the current therapeutic regimens being used, and the emerging pattern of late clinical manifestations of the disease; the immunopathogenesis of the disease; and approaches used to avoid exposure to ticks and the way health care providers can respond to concerns about tick bites.

We encourage questions concerning Lyme disease from readers. If there is a problem that has confronted you in your practice and still is not clear in your mind, the odds are that other practitioners have the same question. We want to dispel the myth and mystery of Lyme disease and make the facts clear, so that New Jersey practitioners can render the best possible medical care.

The Lyme Disease Center at Robert Wood Johnson Medical School currently serves as a referral center for Lyme disease. We try to assist physicians with problems related to individual cases. In addition, the Center is involved in a number of studies that may benefit patients directly, by saving them money, or may ultimately contribute to the understanding of the disease and how to diagnose it.

The Center currently is involved in a study of the treatment of erythema chronicum migrans (ECM), the pathognomonic skin rash seen in early Lyme disease. In order to be entered in this study, a patient must have an ECM skin lesion of at least 5 cm (2 inches). This multicenter study will compare the efficacy of amoxicillin, one of the standard drugs for Lyme disease, with a new drug, azithromycin. Azithromycin is derived from erythromycin, a drug that is less effective in the treatment of Lyme disease than are the tetracyclines or penicillin. However, on the basis of preliminary studies, azithromycin seems as effective as amoxicillin (and much more effective than erythromycin), is better tolerated than the erythromycin, penetrates tissues very well, and is effective after a shorter duration of therapy than amoxicillin. The company that manufactures azithromycin has funded this double-blind comparative study; the drug, our services, and all diagnostic and monitoring studies are free. If you see a patient with ECM who might be interested in this study, please call the Center at 1/908/937-7702 to arrange to enter that patient into the study within 24 hours. At the end of therapy, the Center will communicate all findings to you so that your patient's care will not be interrupted. Your cooperation in this study is greatly appreciated. It will allow us to enroll sufficient patients to prove the efficacy of this exciting new agent and will allow the Lyme Disease Center to proceed with our ongoing research in providing more sensitive and specific diagnostic tests in early Lyme disease. ☐ Leonard Sigal, MD

PLACEMENT FILE

The following physicians have written to the executive offices of MSNJ seeking information on opportunities for practice in New Jersey. If you are interested in information concerning these physicians, we suggest you make inquiries directly to them.

Cardiology

George D. Birmingham, MD, 3531 Salerno Ct., Apt. 5, Middleton, WI 53562. Mount Sinai 1984. Board eligible. Board certified (IM). Group or partnership. Available July 1991.

Family Medicine

Vicente F. Franco, MD, 9362 Bay Colony Dr., Apt. 1S, Des Plaines, IL 60016. Universidad Central del Este 1982. Board eligible. Available July 1991.

Internal Medicine

Thomas P. Hooker, DO, 2804 Sitios St., Tampa, FL 33629. Philadelphia College of Osteopathic Medicine 1984. Board certified; also, PUL. Solo or multispecialty group. Available July 1991.

Marc Kesselhaut, MD, 1 Rustic Ridge, C16, Little Falls, NJ 07424. St. George's University 1986. Board eligible. Solo or partnership in Mercer, Somerset, Burlington, Hunterdon, or Middlesex counties.

M. Stekelman, MD, P.O. Box 900, Hightstown, NJ 08520. BSAS (Argentina) 1959. Also, gastroenterology. Board eligible. Outpatient or ambulatory facility. Available.

Obstetrics/Gynecology

Dennis Tumbokonm, MD, P.O. Box 476, Kimball, WV 24853. University of the East. Board eligible. Solo. Available July 1991.

Pediatrics

Donna Churlin, MD, 55 Montgomery St., Bloomfield, NJ 07003. UMDNJ 1987. Board eligible. Partnership or group in central New Jersey (Essex, Union, or Morris Counties). Available July 1991.

Radiation Oncology

Carol L. Kornmehl, MD, 133 Wyncrest Rd., Marlboro, NJ 07746. SUNY-Downstate 1984. Board certified. Group, partnership, solo. Available July 1991.

Surgery

Nichlas J. Dudas, MD, 915 Princeton Ave., Philadelphia, PA 19111. UMDNJ 1986. Board eligible. Group or partnership.

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The 7th Annual International Symposium on Acupuncture & Electro-Therapeutics will be held at Columbia University, School of International Affairs, 420 W. 118th St., N.Y. City, during October 17-20, 1991.

These meetings are co-sponsored by the International College of Acupuncture & Electro-Therapeutics & its official journal, Acupuncture & Electro-Therapeutics Research, The International Journal (published by Pergamon Press & indexed in 15 major indexing periodicals, including Index Medicus), Heart Disease Research Foundation; NY Pain Center; Electrical Engineering Dept., Manhattan College; Nordic Medical Acupuncture Society (Scandinavia); Schmerz Therapeutische Kolloquium (West Germany); Japan Bi-Digital O-Ring Test Assn.; Accredited toward Acupuncture Certification to practice acupuncture. Eligible for AMA CME Cat. I credit (about 40 credit-hours for the Symposium).

For information on meetings or submission or presentations of papers, contact Symposium Chairman, Prof. Y. Omura, M.D., Sc.D., 800 Riverside Drive (8-I) New York, NY 10032 Tel: (212) 781-6262 (10 am to 10 pm 7 days a week) or (212) 928-0658, Co-chairman, Prof. A.W. Cook, MD (516) 877-1821, or Bro. Michael Losco (212) 920-0162.

CONTINUING EDUCATION

MEDICINE

July

3 **Current Concepts in ACLS—How To Run a Code**
1:30-2:30 P.M.—Central New Jersey Medical Group, New Brunswick
(AMNJ)

9 **Topics in Public Health**

16 12:15-1:30 P.M.—John Fitch Plaza, Trenton
(NJDOH and AMNJ)

9 **Diabetic Retinopathy**
1-2 P.M.—Marlboro Psychiatric Hospital, Marlboro
(AMNJ)

11 **Diabetic Retinopathy**
2-3 P.M.—Welkind Rehabilitation Hospital, Chester
(AMNJ)

17 **Psychoactive Agents in Long-Term Care**
9 A.M.-3 P.M.—Hyatt Regency Hotel, New Brunswick
(AMNJ)

17 **Pulmonary Grand Rounds**
11:30 A.M.-12:30 P.M.—Newcomb Medical Center, Vineland
(AMNJ)

25 **New Developments in Emergency Care**
2-3 P.M.—Woodbridge Developmental Center, Woodbridge
(AMNJ)

25 **Identification and Management of HIV Infection**
2-3 P.M.—Welkind Rehabilitation Hospital, Chester
(AMNJ and NJDOH)

August

6 **Caesarean Section Rates**
12:15-1:30 P.M.—John Fitch Plaza, Trenton
(NJDOH and AMNJ)

16 **Diabetic Retinopathy**
1-2 P.M.—Woodbridge Developmental Center, Woodbridge
(AMNJ)

17 **Pulmonary Grand Rounds**
11:30 A.M.-12:30 P.M.—Newcomb Medical Center, Vineland
(AMNJ)

29 **Lyme Disease**
12 Noon-1 P.M.—Carrier Foundation, Belle Mead
(Carrier Foundation)

PSYCHIATRY

July

11 **Dealing with Anger and Hostility**
12 Noon-1 P.M.—Carrier Foundation, Belle Mead
(Carrier Foundation)

18 **Seizure Disorders**
2:30-3:30 P.M.—Greystone Park Psychiatric Hospital, Greystone Park
(AMNJ)

18 **Autism**
12 Noon-1 P.M.—Carrier Foundation, Belle Mead
(Carrier Foundation)

August

1 **Postpsychotic Depression**
12 Noon-1 P.M.—Carrier Foundation, Belle Mead
(Carrier Foundation)

8 **Transcultural Treatment in Issues in Psychiatry**
12 Noon-1 P.M.—Carrier Foundation, Belle Mead
(Carrier Foundation)

15 **Music Therapy with Psychiatric Patients**
12 Noon-1 P.M.—Carrier Foundation, Belle Mead
(Carrier Foundation)

IN MEMORIAM

GEORGE F. WILLIS

George Francis Willis, the executive director of the Bergen County Medical Society for the past 20 years, died on March 26, 1991, at the age of 75. Mr. Willis, a resident of Oakland, was a respected civic leader and medical society executive. In a testimonial dinner held in July 1991, Representative Marge Roukema said, "Everyone who has come in contact with George over the past two decades has a warm story about his energy, his helpfulness, and his positive attitude. There is no doubt that George has made important contributions to the lives of many of us." And Representative Robert Torricelli added, "George is one of those special few who truly made a difference in our society." Born in Philadelphia in 1915, Mr. Willis was a United States Army Air Corps glider pilot during World War II. He was affiliated with Shell Oil Company as a public relations spokesperson for the Oil Industry Information Committee. Before serving the physicians of New Jersey, Mr. Willis was the coordinator of special programs and events from 1960 to 1970 for the newspaper, *The Record*. Mr. Willis was a member of the National Association for Preservation of Storytelling and of the New Jersey Storytelling Guild. A fundraiser for the American Cancer Society, Mr. Willis was a member of the Bergen County chapter. In 1976, Mr. Willis organized the community ambulance corps for the bicentennial celebration, as thousands gathered along the Hudson River to watch the tall ships. In 1974, Mr. Willis was an advocate for the famine-plagued Ethopian population and coordinated the sending of medical supplies to the country.

NATHAN S. DEUTSCH

Past-president of our Union County component, Nathan Solomon Deutsch, MD, passed away on February 21, 1991. Born in Plainfield in 1909, Dr. Deutsch attended the University of Illinois College of Medicine, Chicago, in 1935 and received his New Jersey medical license in 1937. Specializing in radiology, Dr. Deutsch resided and maintained a practice in Plainfield. Dr. Deutsch was affiliated with Muhlenberg Hospital, Plainfield. He was a diplomate of the American College of Internal Medicine; a member of the American Medical Association, and of the Radiological Societies of New Jersey and North America; president of the Plainfield Board of Health; and medical chief of Plainfield's Civil Defense Council. During World War II, Dr. Deutsch served in the United States Army Medical Corps, stationed in the South Pacific.

CORRADO FRARACCIO

Family practitioner Corrado Fraraccio, MD, died January 23, 1991. Dr. Fraraccio resided in Weehawken, Mantoloking, and Brick Township. Born in Italy on September 9, 1916, Dr. Fraraccio attended the Faculty of Medicine University of Naples, Italy, earning his medical degree in 1941. Dr. Fraraccio maintained a private practice, and was chief of anesthesiology at North Hudson Hospital, Weehawken; and on staff at Christ Hospital, Jersey

City. Dr. Fraraccio was a member of our Hudson County component and of the American Medical Association; a fellow of the American Academy of Family Practice; and certified by the United States Federal Aviation Administration (FAA) to give flight physicals to pilots.

ISIDORE FRIMMER

Born in Austria on September 5, 1905, Isidore Frimmer, MD, passed away on February 7, 1991. Dr. Frimmer received his medical degree from New York Medical College Flower & Fifth Avenue Hospital, New York, in 1931 and completed his internship at St. Elizabeth Hospital and his residency at New York State Psychiatric Institute. Dr. Frimmer earned his New York medical license in 1931, and his New Jersey medical license in 1932. Dr. Frimmer practiced in Elizabeth and the Bronx; he resided in Teaneck. Specializing in psychiatry, Dr. Frimmer was an emeritus staff member at Holy Name Hospital, Teaneck; a member of the Bronx County Medical Society, of our Bergen County component, and of the American Medical Association; and a fellow of the American Psychiatric Association.

NORMAN W. GARWOOD

Born August 25, 1912, in Elmer, Norman William Garwood, MD, died February 27, 1991, at the age of 78. Dr. Garwood earned his medical degree from Hahnemann Medical College and Hospital, Philadelphia, in 1938. One year later, Dr. Garwood received his New Jersey medical license. A pediatrician, Dr. Garwood resided and maintained a private practice in Crosswicks for 50 years. Dr. Garwood was president of the medical staff and chief of pediatrics at Helene Fuld Medical Center, Trenton, and was affiliated with McKinley Hospital, Trenton. Dr. Garwood was a school physician for Northern Burlington High School for 24 years. Dr. Garwood was a fellow of the American College of Sports Medicine, and a member of the American Medical Association and of our Mercer County component.

FREDERICK HNAT

Word has been received of the death of Frederick Hnat, MD, on February 24, 1991, at the age of 88. Dr. Hnat was born June 21, 1902, in Elizabeth and attended Columbia University College of Physicians & Surgeons, New York, earning his medical degree in 1928. Dr. Hnat served an internship at Atlantic City Hospital and a residency at the University of Michigan. Dr. Hnat received his New Jersey medical license in 1930. For many years, Dr. Hnat resided and maintained a practice in Elizabeth. Specializing in internal medicine and cardiology, Dr. Hnat was affiliated with Elizabeth General Hospital. Dr. Hnat was a member of our Union County component and of the American Medical Association, and a fellow of the American College of Physicians. Dr. Hnat was a World War II Army veteran.

HARRY KATZ

A lifelong Paterson resident, Harry Katz, MD, passed away February 21, 1991. Born in Poland on March 15, 1907, Dr. Katz came to the United States as a young child, earning his medical degree from Rush Medical College, Chicago, Illinois, in 1934. He received his New Jersey medical license in 1936. Dr. Katz completed an internship and residency in cardiology at Hillman

Hospital, Alabama, and an internship in psychiatry at Rockland County State Hospital, New York. Specializing in cardiology and psychiatry, Dr. Katz maintained a private practice in Paterson. He served as cardiologist and chief psychiatrist at Barnert Memorial Hospital Center, Paterson; and as consulting psychiatrist for the Little Falls and Newark public school systems and for William Paterson College. A member of the American Medical Association and of our Passaic County component, Dr. Katz was a diplomate of the American Board of Psychiatry. Dr. Katz retired in 1985.

GUY H. LAUDIG

Eighty-year old Guy Henry Laudig, MD, passed away on February 17, 1991. Born in Ringtown, Pennsylvania, in 1910, Dr. Laudig received his medical degree from Harvard University Medical School, Massachusetts, in 1936, and his New Jersey medical license in 1939; he completed an internship at Long Island College Hospital and a residency at Kings County Hospital, New York. A general and neurosurgeon, Dr. Laudig maintained a practice in Morris Plains and was chief of surgery at Morristown Memorial Hospital. Dr. Laudig was a member of our Morris County component and of the American Medical Association, and a fellow of the American College of Surgeons. After retiring in 1980, Dr. Laudig relocated to Nazareth, Pennsylvania. During World War II, Dr. Laudig served as a United States Army surgeon.

JOSEPH PEYSER

Sixty-eight-year-old Joseph Peyser, MD, of Lake Worth, Florida, passed away January 19, 1991. Dr. Peyser was born December 4, 1922, in New York City and earned his medical degree from New York University School of Medicine, in 1948. In 1949, Dr. Peyser received his New Jersey medical license. Dr. Peyser interned at the United States Naval Hospital, New York. A Hillside family practitioner for many years, Dr. Peyser was president of St. Elizabeth General Hospital's medical staff; a diplomat of the American Board of Family Practice; a member of the American Medical Association and of our Union County component; a lieutenant in the United States Navy during World War II; a member of the Hillside Board of Health; and a trustee of the Hillside Ambulance Squad.

KENNETH F. SCHAEFER

On December 10, 1990, Kenneth Franklyn Schaefer, MD, of Aurora, Colorado, passed away at the age of 74. Born in Oaklyn on January 30, 1916, Dr. Schaefer earned his medical degree from the University of Pennsylvania Medical School, Philadelphia, in 1941. After completing an internship at Presbyterian Hospital, Philadelphia, Dr. Schaefer served in the United States Army Medical Corps from 1942 to 1946. Dr. Schaefer received state medical licenses from: Pennsylvania in 1942, New Jersey in 1946, New York in 1953, and Minnesota in 1954. Specializing in insurance medicine, Dr. Schaefer worked for Prudential Insurance Company in Newark and Minneapolis, as medical director, and for the New Jersey State Department of Health, Division of Industrial Health. Dr. Schaefer was a member of the American Medical Association, of our Essex County component, of the Hennepin County Minnesota Medical Society, and of the Minnesota State Medical Association.

EDITORIAL CRITERIA

CONTENT

NEW JERSEY MEDICINE is the official organ of the Medical Society of New Jersey. The goals are educational and informational. All material published is copyrighted by the Medical Society of New Jersey.

The educational contents of each issue appear as scientific articles, based on research, original concepts relative to epidemiology of disease, and treatment methodology; case reports; review articles; clinical notes; state of the art reports; and special articles, that include evaluations, policy and position papers, and reviews of nonscientific subjects. Other topics include professional liability commentary; critical narration; medical history; pediatric briefs; nutrition update; and opinions. Editorials are prepared by the editor and by guest contributors on timely and relevant subjects. The Doctors' Notebook section contains organizational and administrative items from the Medical Society of New Jersey and from the community. Letters to the editor and book reviews are welcome and will be published as space permits.

The principal aim in the preparation of a contribution should be relevance to diagnosis and treatment and to the education of patients and professionals. Preference will be given to authors from New Jersey and to out-of-state lecturers submitting a suitable manuscript based on a presentation made to an audience in New Jersey.

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SPECIFICATIONS

Submit two manuscripts that must be typewritten and double spaced on 8½" by 11" paper. Statistical methods used in articles should be identified.

The title page should include the full name, degrees, and affiliations of all authors, and the name and address of the author to whom reprint requests and correspondence should be sent.

The author should submit a 30-word abstract to be used at the beginning of the article.

Tables must be typewritten and double spaced on separate 8½" by 11" sheets, with a title and number. Symbols for units should be confined to column headings, and abbreviations should be kept to a minimum.

Illustrations should be professional quality, black-and-white glossy prints. The name of the author, figure number, and the top of the figure should be noted on a label attached to the back of each illustration. When photographs of patients are used, the subjects should not be identifiable or publication permission, signed by the subject or responsible person, must be included with the photograph. Material taken from other publications must give credit to the source.

Generic names should be used with proprietary names indicated parenthetically or as a footnote with the first use of the generic name. Proprietary names of devices should be indicated by the registration symbol—®.

The summary of the article should not exceed 250 words; it should contain essential facts.

References should not exceed 35 citations except in review articles, and should be cited consecutively by numbers in parentheses at the end of the sentence. The style of *NEW JERSEY MEDICINE* is that of *Index Medicus:*

1. Goldwyn RM: Subcutaneous mastectomy. *NJ MED* 74:1050-1052, 1977.

PUBLICATION POLICY

Receipt of each manuscript will be acknowledged; the paper will be referred to the Editorial Board. Final decision is reserved for the editor. No direct contact between the reviewers and the authors will be permitted.

All communications should be sent to *NEW JERSEY MEDICINE*, MSNJ, 2 Princess Road, Lawrenceville, NJ 08648. □

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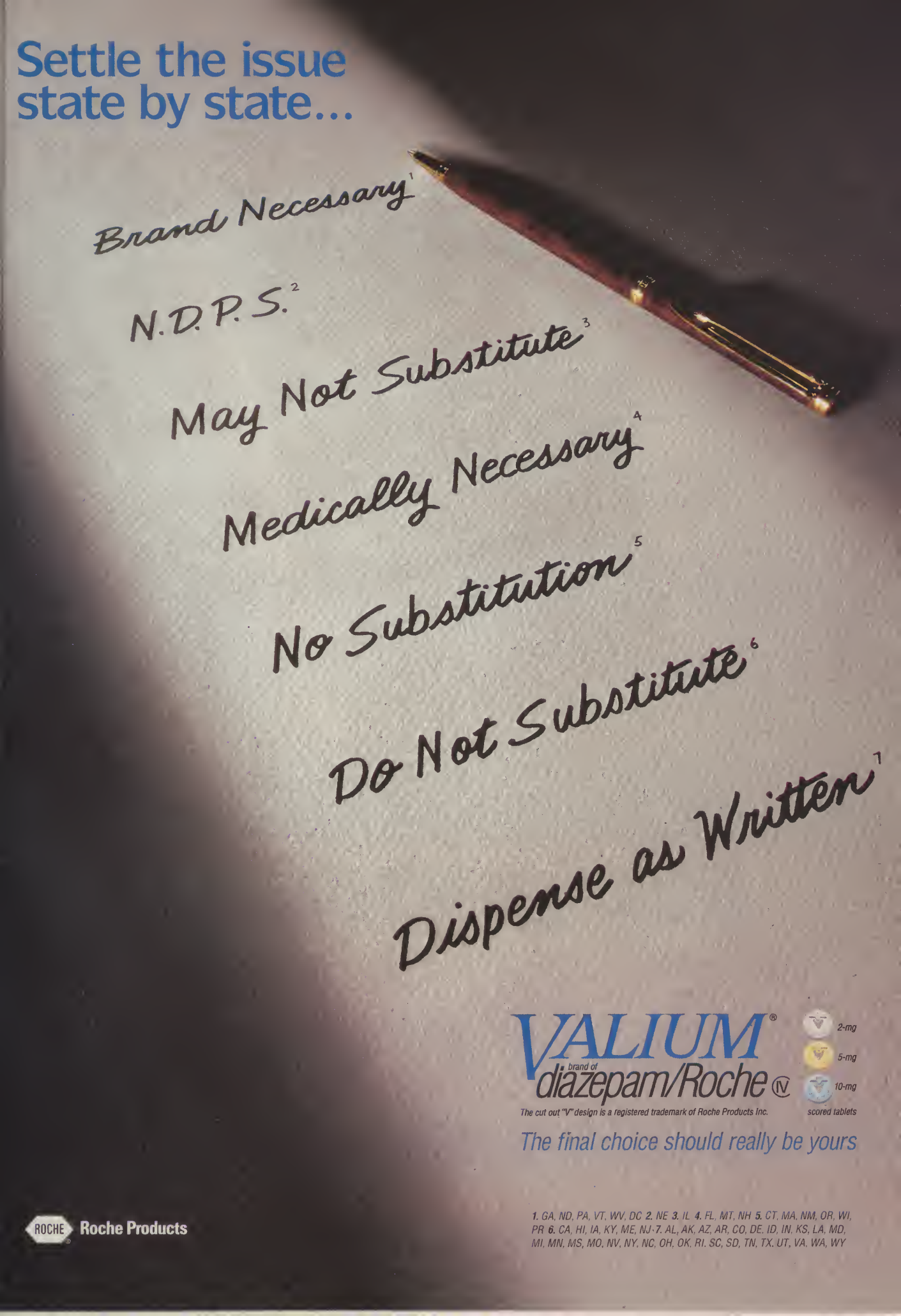
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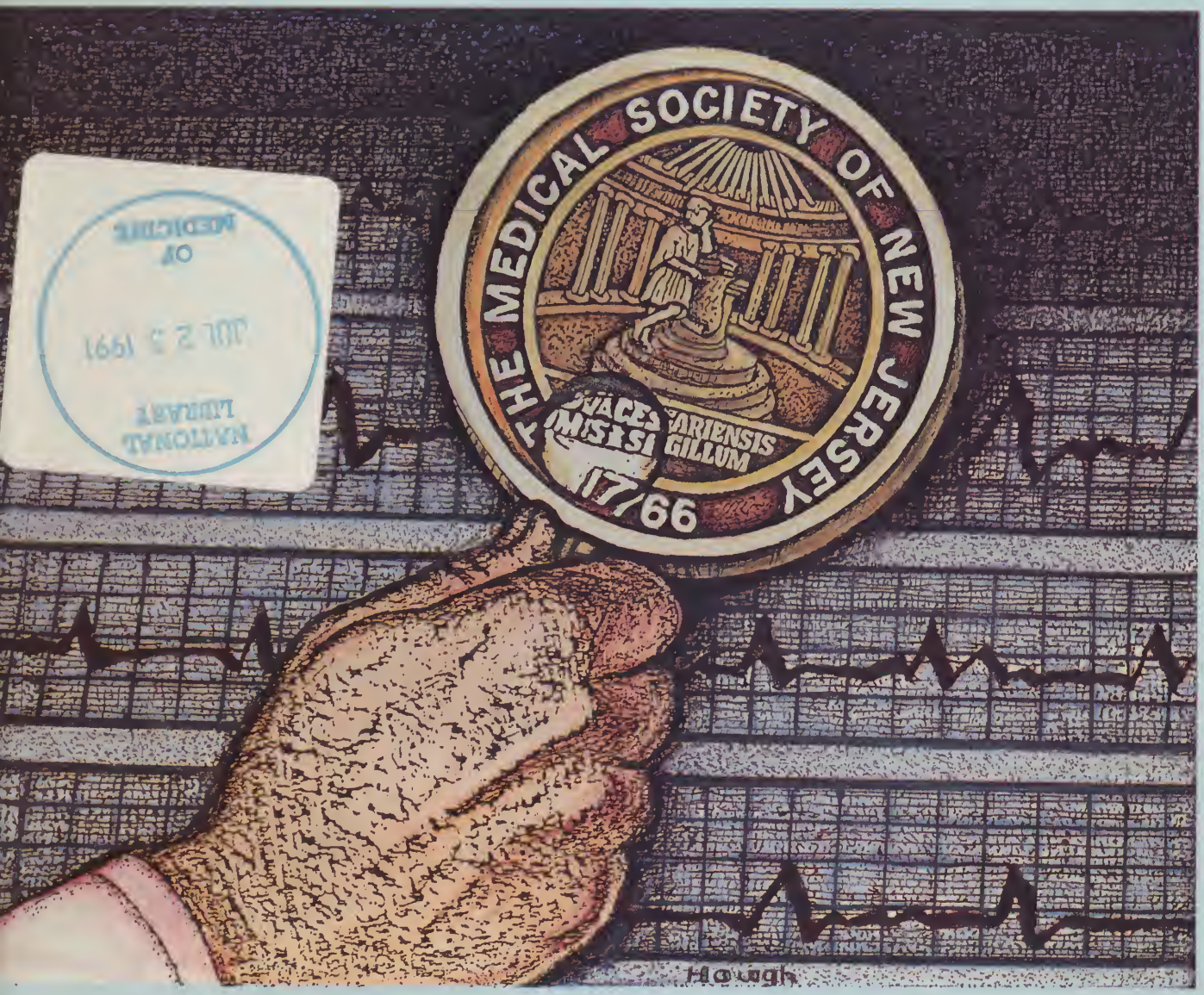
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Newswatch

MSNJ OPPOSES SBME LICENSE RENEWAL FORM...

MSNJ has gone to court for an injunction against the State Board of Medical Examiners (SBME) license renewal form. MSNJ has requested the court to impound any forms that were returned and to order SBME to send out a revised form that does not breach confidentiality or request disclosures in an overly broad and illegal fashion. All members will be advised of the court's decision before July 15.

GLUTETHIMIDE OFFICIALLY SCHEDULE II DRUG...

Glutethimide, commonly known as Doriden, has been made a federal schedule II drug. All requirements for security, prescribing, dispensing, recordkeeping, and ordering for any schedule II drug now apply. Federal order forms (DEA222) are necessary for all purchases of glutethimide products. New Jersey has had glutethimide in schedule II since 1978. Since it was only a state schedule II drug, the provision for order forms did not apply, but now it is mandated.

MEDICARE PHYSICIAN PAYMENT REFORM...

This report by Ian D. Samson, MD, summarizes the Physician Payment Reform Meeting, Health Care Financing Administration (HCFA) III.

1. Global Codes. Phase I rebundling of global codes was introduced in February 1991. Now, 500 to 1,700 codes are being examined with a view to rebundling. These codes will go into effect as phase II in August 1991. The purpose is to limit payment to one CPT code that covers more than one activity. **2.** Volume Target Standard (VTS). VTSs for fiscal year 1992 are established: 4.1 percent for surgery; 7.1 percent for nonsurgical services. For fiscal year 1990, the target increase was 9.1 percent; this was exceeded by 10.1 percent and, as a result, the conversion figure (in dollars) for the RBRVS schedule will be reduced for 1992. **3.** Historical Payment Basis (HPB). HPBs are calculated by actuarial analysis. This provides an estimate of what future fees would be if no fee schedule was instituted. It forms a basis for comparison between fee schedule and usual and customary fees, and will affect the phasing in of the fee schedule over the next four years. **4.** Advisory Committee. This Committee, of seven practicing physicians, will assist with the assessment of concurrent problems. **5.** Global Fees. Initial consultations will be paid. With regard to preoperative visits, payment would not be made until after the decision to operate is made--within 30 days of surgery. In certain instances where there is need for stabilization in a critically ill patient, payment will be made with adequate documentation. There might be revision to this 30-day period section; a 7-day period would be more reasonable. This issue should be addressed to HCFA officials. Payment for multiple intraoperative procedures was discussed. It was noted that the traditional allocation would be upheld, although there appeared to be some uncertainty by HCFA representatives. There is no current

unanimity of action with different carriers. This issue also should be addressed to HCFA officials. And, it is HCFA's intent not to pay for "usual complications." It was noted that no complication is considered "usual" by surgeons. HCFA should be petitioned to alter this ruling. Nevertheless, HCFA does recognize that the more significant complications must be covered. In this instance, payment will be made at the reduced rate of the operative component of fee only. The pre- and postoperative component would be ignored. Payment will be made using this formula if there is a CPT code for the procedure. If not, payment will be made at 50 percent of the initially performed service. In all cases, payment will include 90 days of postoperative care except for unrelated services such as chemotherapy. Where postoperative care is shared, part of the fee will be assigned to the physician co-managing the patient. With regard to minor surgery and "oscopies," no payment will be made for a visit rendered on the same day as the service. There is no postoperative exclusion of payment for visits. **6.** Visit Coding. Coding for visits will be detailed. HCFA plans to accurately describe circumstances for each level of service. Codes will be specific, specialty specific, show interspecialty differences, and take time for consideration. Each code will have relative value unit. Vignettes will be used to illustrate these codes. The system will be introduced in January 1992. **7.** Office Procedures. HCFA is in the process of evaluating those services designated as required office procedures. These services must be performed in an office setting to qualify for 100 percent remuneration. There will be an additional tray fee. **8.** Electrocardiograms (EKGs). The restrictive payment for EKGs extends to preoperative routine EKGs and EKGs read by physicians on contract to hospitals. Physicians are urged to communicate their dissatisfaction with this item to HCFA. **9.** Physician-Supplied Drugs. Physicians would be paid at 85 percent of the wholesale price for drugs supplied to patients as it was felt that drugs could be procured at less than the advertised wholesale price. It was explained to HCFA that physicians do not have the same ability as hospitals and pharmacies to obtain drugs at a discount. Physicians should respond to this inequity.

Actuarial analysis of gains and losses by specialty and state was provided by HCFA. In spite of what seems to be modest reductions in payment for services of about 15 percent, HCFA projects cumulative increases in total budget outlays of up to 75 percent from 1991 to 1996. These figures are puzzling when one looks at some of the proposed payments, e.g. office visit new (1991 average payment, $26; full fee schedule, $22) and removal of gallbladder (1991 average payment, $746; full fee schedule, $525). The value of the conversion factor for application to the RBRVS in 1992 is to be $26.87. However, this figure already is slated for reduction of 16 percent. A 6 percent reduction is being imposed because the 1990 VTS was exceeded by 10 percent. A further 10.5 percent will be slashed due to an anticipated increase in physician services to offset their drop in income. The fee schedule is clearly aimed at cost cutting, without overt rationing of services. It would seem that physicians are destined for drastic cuts in payment under the guise of payment reform. Dr. Todd has responded vigorously on behalf of the AMA.

All physicians should send their comments to HCFA by August 5, 1991: Health Care Financing Administration, Department of Health and Human Services, Attention: BPD-712-P, PO Box 2668, Baltimore, MD 21207.

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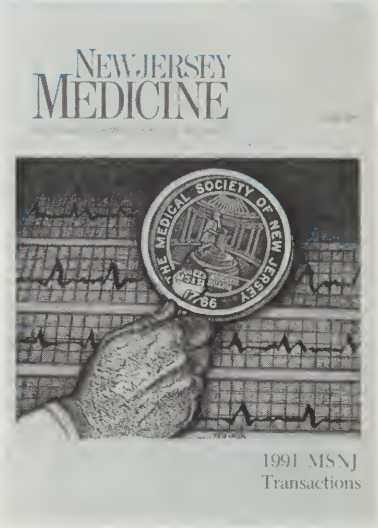
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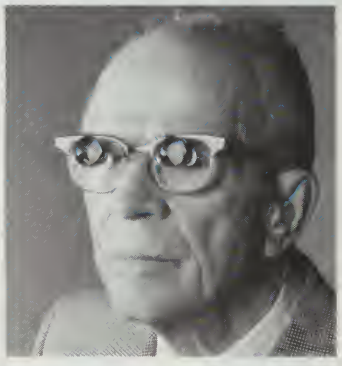
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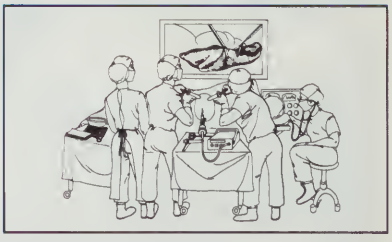
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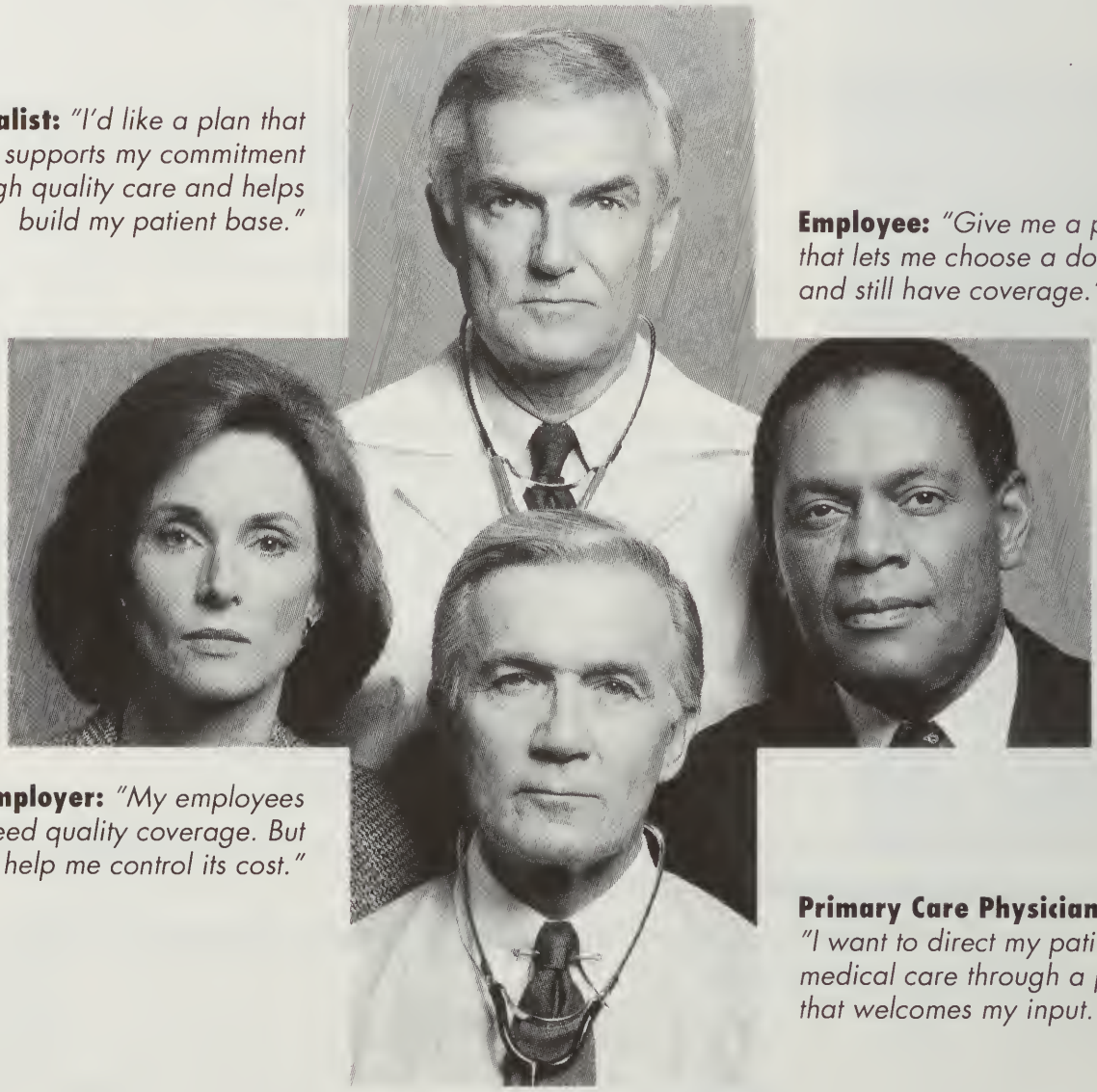
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MSNJ NEWSLETTER

MEDICARE HISTORICAL PAYMENTS

A new system for reimbursing physicians for their care of Medicare patients will go into effect in 1992. A Medicare fee schedule will be established and the same payment amount will be made for the same procedure to each physician billing in the same geographic locality. A doctor's specialty will not impact on the amount of reimbursement.

However, while the fee schedule amounts will be uniform for each procedure, Congress required that the fee schedule be phased-in over several years to lessen the immediate impact on some physicians. This phase-in period is required in situations where there are significant variations between what currently is being paid for a procedure, what is known as the historical payment, and what would be paid under the fee schedule.

In situations where the historical payment varies from the fee schedule amount by at least 15 percent, either above or below, a blended payment will be made in 1992, and an updated blended payment will be made thereafter. If it varies by less than 15 percent, then the fee schedule amount will be paid.

Some examples may help illustrate this situation:

The historical payment in a locality for procedure 99999 is $80. The Medicare fee schedule amount is $100. Since the difference is 20 percent, a blended payment amount will be used in 1992. The payment would be the sum of the historical payment ($80) plus 15 percent of the fee schedule amount ($100 x 15 percent or $15). Thus the payment amount for that procedure in 1992 would be $95 ($80 + $15).

In another locality, the historical payment for procedure 99999 is $90. Since the Medicare fee schedule amount is $100, the difference is less than 15 percent. Therefore, in that locality, the fee schedule amount of $100 will be paid for services performed on or after January 1, 1992.

The historical payment is a calculation that represents the average allowed amount in a locality for each procedure. Obviously, the calculation of this amount is critical to the implementation of the physician fee schedule and the determination of whether a transition payment will be made for a given procedure. Your Medicare carrier will be making this calculation this summer and using it as a comparison this fall when the Health Care Financing Administration (HCFA) publishes the final fee schedule relative value units and conversion factor in October. Each individual physician will be notified in late November of the payment rates for pertinent procedures that will go into effect in 1992. ☐ Maurice Hartman, Regional Administrator, HCFA

GERIATRIC REVIEW COURSE

An intensive geriatric review course will be held October 3 to 6, 1991, at the Hyatt Hotel in Cherry Hill. This comprehensive course will cover a broad array of topics in geriatric medicine and will be presented by recognized experts. While specifically geared for internists and general practitioners preparing for the geriatric boards, this course also is designed to provide an update on geriatric medicine for all physicians. Cosponsored by the New

Jersey Geriatric Education Center, the American College of Osteopathic Internists, and the American College of General Practitioners, this program is endorsed by the American Osteopathic Association. For more information and registration materials, please contact the New Jersey Geriatric Education Center, University of Medicine and Dentistry of New Jersey–School of Osteopathic Medicine, Center for Aging, 301 S. Central Plaza, Suite 3200, Stratford, NJ 08084-1504, 1/609/346-7141.

HOME CARE FOR AIDS PATIENTS

Community Services of Visiting Nurse Association, Inc. has received a grant of $17,179 from the New Jersey State Department of Health, Division of AIDS, to be used to provide home and community-based services to individuals with AIDS or HIV infection to enable individuals to remain in the community, or to return to the community, rather than be cared for in a long-term care facility or a hospital setting.

To be eligible for this program, individuals must be diagnosed as having AIDS or HIV infection; must have physician certification that they are in medical need of the covered home care services specified in the service plan; and that covered services must not be reimbursable under other health insurance/payment mechanisms including state Medicaid, Title 19, or ACCAP. Individuals must be residents of New Jersey for at least 30 days prior to application.

The household income must be in accord with specific standards and proof of monthly income in the 30 days preceding the date of application must be provided.

An application form must be completed by each individual applying for services under the program. For further information, contact, Janice Sias, Case Management Coordinator, Community Services of VNA, Inc., P.O. Box 441, Trenton, NJ 08603.

HOSPITAL CHANGES

The following line was approved for addition to N.J.A.C. 8:31B-3.73(a)1i at the March 14, 1991, meeting of HCAB: "Hospitals shall be reconciled to the lower of aggregate charges or approved revenue for the rate year, utilizing the cost and billing data submitted pursuant to N.J.A.C. 8:31B-3.73(a)1i." It appears that there has been a trend for charges to be set at a level significantly below DRG rates and the gap has been growing over the last two years. This can cause a number of problems, including: hospitals not collecting all entitled reimbursement, worsening undercollection problems, increased number of patient appeals of bills for which DRG rates are significantly higher than charges and, challenges to the accuracy of the health care reimbursement system. A number of concerns to this proposal were raised by the industry. The main ones were: this regulation will require hospitals to set outpatient rates at levels that may be unaffordable for many patients, there was no information about how the new requirements will be implemented or enforced and, a transitional methodology should be developed to allow hospitals time to update their charges.

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Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalmic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

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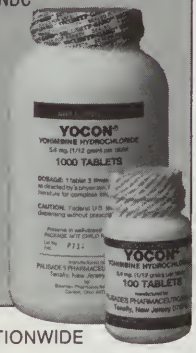
Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.[1,2] Also dizziness, headache, skin flushing reported when used orally.[1,3]

Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.[1,3,4] 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to ½ tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.[3]

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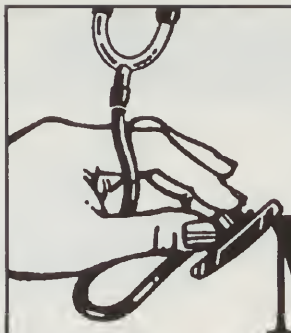
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2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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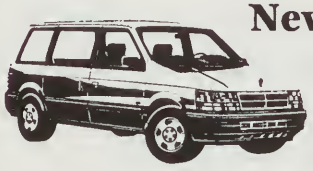
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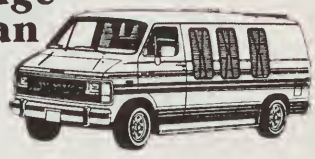
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COURT DECISION IN BEHRINGER CASE

On April 25, 1991, a New Jersey trial judge issued a potentially significant decision involving the practice rights of health professionals with AIDS and the confidentiality rights of AIDS patients.

Judge Philip S. Carchman of the Mercer County Law Division of the State Superior Court made the ruling in the case of *Estate of William Behringer, MD, v. The Medical Center at Princeton et al.* The ruling generally supported the hospital's actions in limiting Dr. Behringer's privileges, but declared that the hospital owed damages to Dr. Behringer's estate as a result of violations of patient confidentiality.

A board-certified otolaryngologist and a plastic surgeon with privileges at The Medical Center at Princeton, Dr. Behringer was admitted to the hospital's emergency department at 11:00 P.M. on June 16, 1987, with pulmonary distress. He subsequently was admitted as an inpatient, and a bronchoscopy was performed.

Dr. Behringer signed a special consent form for an HIV blood test and was told that the bronchoscopy could result in a determination that he had Pneumocystis carinii pneumonia, an AIDS-defining event. However, he received no special counseling.

On the following day, June 17, the test was performed and the diagnosis of AIDS was made. The treating physician was sensitive to the special need for confidentiality arising from Dr. Behringer's status as a member of the hospital's medical staff who had practiced in the Princeton area for ten years. At approximately 4:30 P.M., Dr. Behringer was allowed to walk out of The Medical Center at Princeton as a discharged patient, and the diagnosis was noted on his chart.

Rumors immediately ensued: Judge Carchman's opinion stated:

> No effort was made to keep knowledge of this diagnosis limited to persons involved in the patient's care. There was no written or verbal restriction against any health care worker involved in plaintiff's care discussing plaintiff's diagnosis with other Medical Center employees. Employees not involved in his case did learn of plaintiff's diagnosis . . . within hours of the diagnosis, word of plaintiff's illness was 'on the street.'

That evening, Dr. Behringer received telephone calls at his home referring to the diagnosis and extending sympathy.

Almost immediately, the hospital's chief executive officer (CEO) cancelled Dr. Behringer's pending surgery cases. The chief of surgery opposed the cancellation. A five-member committee that included both the CEO and the surgical chief voted against a summary suspension, although the previously scheduled cases remained cancelled. Dr. Behringer's surgical privileges never were reinstated.

A series of meetings to discuss Dr. Behringer's privileges followed. On July 13, the executive committee of the medical staff voted, over the CEO's objections, that "HIV positivity alone" is not a sufficient reason to restrict the practice of a health care worker. The committee was impressed with the opinion that no one had ever contracted AIDS from a health care worker.

The hospital's board of trustees voted on July 20 to require a special informed consent form for patients undergoing procedures performed by Dr. Behringer. The form noted Dr. Behringer's status and "the potential risk of transmission." Effectively this requirement served as a de facto prohibition on his practice.

In December 1987, a joint conference committee of the board and medical staff were advised of the opinion of the American Medical Association Council on Ethical and Judicial Affairs that disclosure of a physician's positive HIV status serves no useful purpose and that, if a risk of transmission to the patient exists, the physician should not perform the activity.

On June 27, 1988, based on the recommendation of the medical staff, the board adopted a policy prohibiting health care workers from performing "procedures that pose any risk of HIV transmission to the patient." Dr. Behringer's privileges were suspended under this policy.

Dr. Behringer retained an office practice until his death on July 2, 1989.

The suit brought by Dr. Behringer's estate alleged that the hospital violated the New Jersey Law Against Discrimination, *N.J.S.A.* 10:5-1 et seq., by placing restrictions on his practice rights due to his medical condition. The suit further alleged that the hospital violated its duty to maintain patient confidentiality. The duty of confidentiality is codified in *N.J.S.A.* 2A:84A-22.1 et seq. and is based ultimately on the constitutional right of privacy. (Legislation enacted in 1990 specifically protects the confidentiality of AIDS patients, *N.J.S.A.* 26:5C-1 et seq.)

Expert witnesses were divided on the issue of whether a patient is entitled to know that a surgeon has AIDS. But, the court noted

that a physician must disclose those facts and risks that "a reasonably prudent patient would consider material or significant in making the decision about what course of treatment, if any, to accept," a standard drawn from the case of *Largey v. Rothman,* 110 N.J. 204 (1988).

In addition, patients require protection from a "reasonable probability of substantial harm" under the standard articulated in *Jansen v. Food Circus Supermarkets* 110 N.J. 363 (1988). In weighing the physician's rights against the patient's rights, stated Judge Carchman, the "patient's rights must prevail." He added: "If there is to be an ultimate arbiter of whether the patient is to be treated invasively by an AIDS-positive surgeon, the arbiter will be the fully informed patient."

Accordingly, the court held that, on the facts presented before it in the Behringer case and based on information about risks known to the hospital in 1987 and 1988, the hospital was within its rights by placing restrictions on this surgeon's privileges. The question of whether hospitals must place such restrictions on the privileges of physicians with AIDS was not before the court.

The hospital's conduct, and not the physician's conduct, was at issue in this case. Consequently, the court was in no position to decide what information had to be disclosed to patients or whether the physician had a right to continue to practice with or without disclosing information to his patients.

On the issue of patient confidentiality, the court was highly critical of the hospital's performance. "The record is devoid of any evidence," said Judge Carchman, "that pretest counseling was administered to plaintiff either by the treating physician or by hospital personnel." In addition, he said, the consent form is "troubling on its face," because it says that the result will be reported "only to the ordering physician," even though access to the patient's chart was, in the court's words, "virtually without restriction."

The court found that the Medical Center had a duty to take "reasonable measures" to protect confidentiality. The judge quoted a federal district court opinion in the case of *Doe v. Barrington,* 729 F. Supp. 376, 384 (D.N.J., 1990): "the privacy interests in one's exposure to the AIDS virus is even greater than one's privacy interests in ordinary medical records because of the stigma that attaches with the disease." The chart, said Judge Carchman, should be secured, or portions of it sequestered—precautions that clearly had not been taken in the Behringer case.

As a result of the disclosure, Dr. Behringer sustained a loss in his social relationships and a pattern of appointment cancellations. Office staff members quit. He suffered, said the court, "both emotionally and financially." These losses will be considered when Judge Carchman determines the amount of damages that the hospital owes to this estate, a decision that is expected shortly.

This case is particularly interesting because, as Judge Carchman stated, it "raises novel issues of a hospital's obligation to protect the confidentiality of an AIDS diagnosis of a health care worker, as well as a hospital's right to regulate and restrict the surgical activities of an HIV-positive doctor." This was only a trial court opinion (issued in a case tried before a judge without a jury), and both sides have the option of appealing to a higher court.

This case was not discussed in the MSNJ House of Delegates, or at the hearing of Reference Committee "B" on Resolution #4, supporting periodic universal HIV testing of health care workers and universal HIV testing of hospital patients. ☐ James E. George, MD, JD, and Neil E. Weisfeld, JD, MSHyg

One Of A Kind



Please see Brief Summary of Prescribing Information on adjacent page.

Glaxo/ ROCHE

Zantac® 150 Tablets
(ranitidine hydrochloride)

Zantac® 300 Tablets
(ranitidine hydrochloride)

Zantac® Syrup
(ranitidine hydrochloride)

CONDENSED BRIEF SUMMARY

The following is a brief summary only. Before prescribing, see complete prescribing information in Zantac® product labeling.

INDICATIDNS AND USAGE: Zantac® is indicated in:
1. Short-term treatment of **active duodenal ulcer.** Most patients heal within four weeks.
2. **Maintenance therapy** for duodenal ulcer patients at reduced dosage after healing of acute ulcers.
3. The treatment of **pathological hypersecretory conditions** (eg, Zollinger-Ellison syndrome and systemic mastocytosis).
4. Short-term treatment of **active, benign gastric ulcer.** Most patients heal within six weeks and the usefulness of further treatment has not been demonstrated.
5. Treatment of **gastroesophageal reflux disease (GERD).** Symptomatic relief commonly occurs within one or two weeks after starting therapy and is maintained throughout a six-week course of therapy.

In active duodenal ulcer; active, benign gastric ulcer; hypersecretory states; and GERD, concomitant antacids should be given as needed for relief of pain.

CONTRAINDICATIONS: Zantac® is contraindicated for patients known to have hypersensitivity to the drug.

PRECAUTIDNS: General: 1. Symptomatic response to Zantac® therapy does not preclude the presence of gastric malignancy. 2. Since Zantac is excreted primarily by the kidney, dosage should be adjusted in patients with impaired renal function (see DDSAGE AND ADMINISTRATIDN). Caution should be observed in patients with hepatic dysfunction since Zantac is metabolized in the liver.

Laboratory Tests: False-positive tests for urine protein with Multistix® may occur during Zantac therapy, and therefore testing with sulfosalicylic acid is recommended.

Drug Interactions: Although recommended doses of Zantac do not inhibit the action of cytochrome P-450 enzymes in the liver, there have been isolated reports of drug interactions that suggest that Zantac may affect the bioavailability of certain drugs by some mechanism as yet unidentified (eg, a pH-dependent effect on absorption or a change in volume of distribution).

Pregnancy: ***Teratogenic Effects: Pregnancy Category B:*** Reproduction studies have been performed in rats and rabbits at doses up to 160 times the human dose and have revealed no evidence of impaired fertility or harm to the fetus due to Zantac. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

Nursing Mothers: Zantac is secreted in human milk. Caution should be exercised when Zantac is administered to a nursing mother.

Pediatric Use: Safety and effectiveness in children have not been established.

AOVERSE REACTIONS: Headache, sometimes severe, seems to be related to Zantac® administration. Constipation, diarrhea, nausea/vomiting, abdominal discomfort/pain, and, rarely, pancreatitis have been reported. There have been rare reports of malaise, dizziness, somnolence, insomnia, vertigo, tachycardia, bradycardia, atrioventricular block, premature ventricular beats, and arthralgias. Rare cases of reversible mental confusion, agitation, depression, and hallucinations have been reported, predominantly in severely ill elderly patients. Rare cases of reversible blurred vision suggestive of a change in accommodation have been reported.

In normal volunteers, SGPT values were increased to at least twice the pretreatment levels in 6 of 12 subjects receiving 100 mg qid intravenously for seven days, and in 4 of 24 subjects receiving 50 mg qid intravenously for five days. There have been occasional reports of hepatitis, hepatocellular or hepatocanalicular or mixed, with or without jaundice. In such circumstances, ranitidine should be immediately discontinued. These events are usually reversible, but in exceedingly rare circumstances death has occurred.

Blood count changes (leukopenia, granulocytopenia, thrombocytopenia) have occurred in a few patients. These were usually reversible. Rare cases of agranulocytosis, pancytopenia, sometimes with marrow hypoplasia, and aplastic anemia have been reported.

Although controlled studies have shown no antiandrogenic activity, occasional cases of gynecomastia, impotence, and loss of libido have been reported in male patients receiving Zantac, but the incidence did not differ from that in the general population.

Incidents of rash, including rare cases suggestive of mild erythema multiforme, and, rarely, alopecia, have been reported, as well as rare cases of hypersensitivity reactions (eg, bronchospasm, fever, rash, eosinophilia), anaphylaxis, angioneurotic edema, and small increases in serum creatinine.

OVERDOSAGE: Information concerning possible overdosage and its treatment appears in the full prescribing information.

DOSAGE AND ADMINISTRATION: (See complete prescribing information in Zantac® product labeling.)

Dosage Adjustment for Patients with Impaired Renal Function: Dn the basis of experience with a group of subjects with severely impaired renal function treated with Zantac, the recommended dosage in patients with a creatinine clearance less than 50 ml/min is 150 mg or 10 ml (2 teaspoonfuls equivalent to 150 mg of ranitidine) every 24 hours. Should the patient's condition require, the frequency of dosing may be increased to every 12 hours or even further with caution. Hemodialysis reduces the level of circulating ranitidine. Ideally, the dosage schedule should be adjusted so that the timing of a scheduled dose coincides with the end of hemodialysis.

HDW SUPPLIEO: Zantac® 300 Tablets (ranitidine hydrochloride equivalent to 300 mg of ranitidine) are yellow, capsule-shaped tablets embossed with "ZANTAC 300" on one side and "Glaxo" on the other. They are available in bottles of 30 (NDC 0173-0393-40) tablets and unit dose packs of 100 (NDC 0173-0393-47) tablets.

Zantac® 150 Tablets (ranitidine hydrochloride equivalent to 150 mg of ranitidine) are white tablets embossed with "ZANTAC 150" on one side and "Glaxo" on the other. They are available in bottles of 60 (NDC 0173-0344-42) and 100 (NDC 0173-0344-09) tablets and unit dose packs of 100 (NDC 0173-0344-47) tablets.

Store between 15° and 30° C (59° and 86° F) in a dry place. Protect from light. Replace cap securely after each opening.

Zantac® Syrup, a clear, peppermint-flavored liquid, contains 16.8 mg of ranitidine hydrochloride equivalent to 15 mg of ranitidine per 1 ml in bottles of 16 fluid ounces (one pint) (NDC 0173-0383-54).

Store between 4° and 25° C (39° and 77° F). Dispense in tight, light-resistant containers as detined in the USP/NF.

September 1990

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BOOK REVIEWS

ANNUAL REVIEW OF MEDICINE

William P. Creger. Palo Alto, CA, Annual Reviews, Inc., 1991. Annual Review of Medicine: Selected Topics in the Clinical Sciences continues the quality tradition of this annual series. The 50 articles present an admirable range of combined usefulness and scholarship. The sentences and style are very clear, and the references useful. It distinctly is not a collection of reprints of published articles.

Special mention should be made of the combined index of chapter titles of volumes 38 to 42 in the last nine pages. In small print, there is a list of all the articles in the 1988 to 1991 annual reviews under 16 topic headings, including cardiovascular system, gastrointestinal system, clinical pharmacology, endocrinology and metabolism, immunology, infectious diseases, surgical topics, transfusion practice in the 1990s, and parenteral and enteral nutrition.

This edition lives up to its reputation. Do browse through it. ☐ Morris Soled, MD

AUTOIMMUNITY AND TOXICOLOGY

ME Kammüller; N Bloksma; W Seinen. New York, NY, Elsevier Science Publishing Company, 1989. This text, *Autoimmunity and Toxicology: Immune Disregulation Induced by Drugs and Chemicals,* is an extremely interesting book focusing on the induction of autoimmune diseases or hypersensitivity responses after the introduction of a toxic substance. This is best exemplified as reactions to various drugs. The major thrust of this book focuses upon the experimental approaches identifying the potential for drugs or chemicals to induce hypersensitivity or autoimmune disorders and provides an excellent review of the literature (up to 1989) involved in this area. The text is divided into sections as an introduction to a variety of drug, chemical, and toxicological implications of autoimmune diseases with a primary focus of basic mechanisms and theories of autoimmune disorders. The following sections review a variety of agents known to cause autoimmune responses in humans such as procainamide, hydralazine, D-penicillamine, diphenylhydantoin, nitrofurantoin, halothane, and other amphiphilic agents. There are specific chapters focusing on the chemical and immunological properties associated with these specific agents that induce autoimmune response. The final section is devoted to the variety of experimental approaches in animal models used in the detection of chemical-induced autoimmunity with a critical assessment of the limitations of these "routine toxicity tests," and suggestions for their possible improvement over time. This book is a superb complement to anyone's interest in hypersensitivity responses that occur in the environment. This book provides the foundation of immunological responses to non-mast-cell mediated processes associated with the typical allergic responses. ☐ Leonard Bielory, MD

CARING FOR THE EXERCISING WOMAN

Ralph W. Hale, MD. New York, NY, Elsevier Science Publishing Co., Inc., 1991. This is a well-written and concise book dealing

with women in athletic participation at all levels. Dr. Hale has had a long interest in the female athlete and has chosen excellent authors to cover all aspects of the subject. The book is thoroughly referenced and adequately illustrated. All aspects of physiology, endocrinology, gynecology, and pregnancy are discussed in some detail relative to the female athlete. Common injuries are listed, but details are left to other texts on the subject. A chapter of special interest concerns exercise and the geriatric female. There is no question that a properly supervised exercise program can improve the quality of life for many of our senior citizens.

I recommend the book to physicians dealing with females participating in athletic activities as a valuable reference. ☐ Christine E. Haycock, MD

OCULAR IMMUNOLOGY TODAY

M. Usui; S. Ohno; K. Aoki. New York, NY, Elsevier Science Publishing Company, Inc., 1990. This book is the compilation of the fifth international symposium on the immunology and immunopathology of the eye. Immunology is one of the most rapidly developing fields in medicine. The book covers an extensive evolution of the ophthalmological evaluation of the immunological aspects of ocular diseases. The text focuses on the allergic responses involving the eye, including discussion on mast cell subtypes and the various forms of conjunctivitis; the use of cyclosporine and the management of conjunctivitis; and the analysis of tears. There is a section dedicated to the relatively new area of cytokine research including gamma-interferon, interleukin-8, and tumor necrosis factor involvement in various inflammatory conditions of the eye. In addition, the new area of molecular biology is unveiled in the identification of various types of fragments that may be involved in the stimulating inflammation of the uveal track (uveitis). All-in-all, this is a unique text for physicians interested in "immuno"-ophthalmology since it permits one to have the essence of this most unique symposium without having been there. ☐ Leonard Bielory, MD

THYROID DISEASES

Stephen Falk. New York, NY, Raven Press, 1990. This publication fulfills the need for an explanatory treatment of the latest techniques for imaging and diagnosis of thyroid diseases. While this book is not a large volume, the editor condensed the views of a broad range of contributors to achieve this manageably-sized monograph.

After a precise review of the anatomy of the thyroid and parathyroid, an extensive discussion of the physiology is presented. The body of the text progresses in an orderly fashion to pathology, diagnosis, and treatment of the thyroid and parathyroid glands. These chapters devote substantial consideration to the potential pitfalls of diagnosis and the benefits of various treatment regimens. This allows the reader to attain a firm understanding of the field. Overall, the text is written clearly with a logical approach to each subject. Liberal use of nuclear scans, computed tomographs, and pathological specimens complements the text. The lengthy commentary on Grave's disease is top notch. The section addressing nuclear medicine encompasses the areas of dosimetry, and in vivo and in vitro techniques. My preference would have been to see a more expansive examination of image interpretation.

The editor and contributors should be congratulated for their practical approach to the diagnosis and treatment of thyroid and parathyroid diseases. ☐ Neil B. Horner, MD

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EDITOR'S DESK



AFTERMATH

The 1991 Annual Meeting of the Medical Society of New Jersey included a few early skirmishes on such items as uncompensated care and funding of medical students, but it was expected that the real battle would be joined on April 30, when the last committee reported on Resolution #4: HIV Testing for Hospital Patients.

The report of the Medical Society's Reference Committee "B" included: "The Reference Committee objects to the Resolution's emphasis on the enactment of legislation and preferred the adoption of policies on HIV Testing:"

> (1) The Reference Committee recommends the resolved be deleted and amended to read as follows:
>
> **Resolved,** that MSNJ support universal HIV testing to be performed on all hospitalized patients; and be it further
>
> **Resolved,** that MSNJ support periodic universal testing of all health care personnel, including physicians; and be it further
>
> **Resolved,** that any individual who tests positive on both the ELISA and Western blot tests be so informed and receive counseling; and be it further
>
> **Resolved,** that any HIV test results be treated with the utmost confidentiality.
>
> (2) The Reference Committee recommends that Resolution #4 be adopted as amended.

Many of us anticipated the worst—debate that would continue interminably. Not so. Speaker after speaker rose to laud the Reference Committee for finally proposing what many physicians and nurses had urged for years. The sentiment was so overwhelming that debate could not be terminated until a negative voice was heard; one finally emerged, but was a lone cry against the near-unanimous support of Resolution #4 by the House of Delegates. It was refreshing to note the compliance of the House in dealing with policies, rather than the many details that, of necessity, must be handled secondarily.

Reaction was swift: Several homosexual groups objected because the resolution would cause further discrimination. The media called it an MSNJ knee-jerk reaction to the Superior Court decision regarding an AIDS-infected surgeon at The Medical Center at Princeton. (In truth, Resolution #4 was submitted for consideration months before the court decision was rendered.) Civil rights spokespersons wrote and spoke about the sanctity of the individual. Etc., etc., etc.

But support for our position surfaced in other quarters. Notable among these were: At its annual meeting in June 1991, the AMA Board of Trustees recommended that its House of Delegates consider routine testing. (The vote should be known by the time this editorial is in print.) Articles supporting a change in the status quo appeared, notably in the May 23, 1991, issue of *The New England Journal of Medicine,* questioning the "exceptionalism" of HIV testing. The Medical Society of the State of New York called on the state Legislature to allow individuals to be

tested for HIV status when medically indicated, "just like any other laboratory test." Etc., etc., etc.

Ten years have passed since AIDS was first reported and an estimated 10 million people currently are infected. It is expected that 40 million will be affected by the year 2000. No group will be immune; some will be at higher risk than others; none will be risk free.

We are hopeful that the medical and public health aspects of the problem no longer will be overwhelmed by the social and political ones and that the innocent and unknowing will receive some measure of protection.

We hope that the homosexual groups will understand that other populations in New Jersey pose more concerns with AIDS than they do. Drug-related AIDS has been our number one problem for years, but these unfortunates have had no credible spokespersons. And the women of child-bearing age represent the fastest-growing population with AIDS; the New Jersey State Department of Health has a special office to deal with the problem.

We hope that people who are HIV-positive or who are at special risk understand that evidence is accumulating to show early treatment leads to longer and better-quality survival. We have seen universally fatal malignancies of the past yield to new modalities. We must be optimistic that a cure for AIDS also will be found, but those affected must still be alive when that day comes. Present-day therapy can help, but only if the population needing treatment can be identified.

We hope that other public health disasters can be prevented. AIDS is devilish enough, but the immunocompromised person also acts as a reservoir for other transmittable ills. Recent reports about the development of drug-resistant tuberculosis must cause concern.

We hope that we can stimulate the needed cooperation of all necessary parties—patients, treaters (or providers), legislators, administrators, regulators, insurance companies, governmental executives, and the courts—to do what is right: to preserve life, liberty, and the pursuit of happiness. Trade-offs should be minimal and the time and money will be well spent. The time is now. ☐ Howard D. Slobodien, MD

> There are two kinds of minorities—those that the majority sets apart, and those that set themselves apart. ☐ Anonymous

> A man must ride alternately on the horses of his private and his public nature. ☐ Ralph Waldo Emerson, "The Conduct of Life," Fate, 1860

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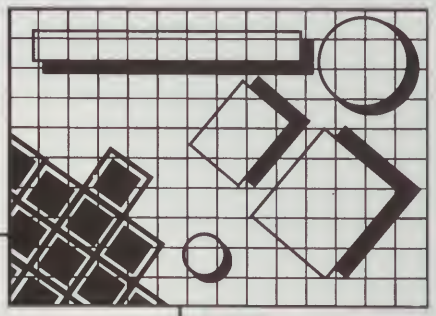
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PRESIDENT 'S PAGE

ACTION ON AIDS

With an estimated one million cases of HIV in the United States by the year 2000, the picture of AIDS today is a reflection of an epidemic in infancy. Currently, the period from initial contact to manifestation of symptoms ranges between 7 and 12 years. Thus, current AIDS statistics give only a partial picture of the coming decade. Some experts predict that for every AIDS patient diagnosed in the 1980s, nine patients will be diagnosed in the 1990s.

At its Annual Meeting on April 30, 1991, the Medical Society of New Jersey House of Delegates took bold measures regarding the AIDS crisis. After much deliberation, discussion, and debate, the House adopted four resolutions:

1. That MSNJ support universal HIV testing to be performed on all hospitalized patients.

2. That MSNJ support periodic universal testing of all health care personnel, including physicians.

3. That any individual who tests positive on both the ELISA and Western blot tests be so informed and receive counseling.

4. That any HIV test results be treated with the utmost confidentiality.

The House took strong action for three reasons: a desire to identify HIV positive patients, deep concern to care for these patients early on, and to protect those individuals who render that care.



Joseph A. Riggs, MD

With universal precautions being used in most hospitals, transmission from health care workers to patients is extremely unlikely. However, transmission of the AIDS virus from patients to health care workers is a potential threat many of us face.

On June 9, the MSNJ Board of Trustees directed that the report prepared by the Task Force on AIDS, the House of Delegates Resolution #4, and an explanatory message be sent to all New Jersey's hospital medical staffs.

I encourage you to read these documents and to study them.

Physicians on staff in each hospital must decide how best to improve the philosophy of broader, more universal HIV testing. No issue is more pressing to the medical community in New Jersey today; no issue affects our patients, our colleagues, and ourselves with greater complexity and urgency.

In addition, a conference, "Testing for HIV: Why, Who, When, and Where," is being sponsored by MSNJ, the New Jersey Hospital Association, the Academy of Medicine of New Jersey, and the Hospital Research and Educational Trust. It is scheduled for October 30, 1991. Please save that date for this important conference.

In New Jersey, there are approximately 162,000 cases of HIV. There have been 10,592 AIDS cases in New Jersey reported to the Centers for Disease Control, with 22 percent (2,300 cases) noted in women, and 3 percent (320 cases) noted in children. AIDS cases are increasing rapidly in New Jersey, with 205 cases being identified each month.

According to the Centers for Disease Control, AIDS now is spreading faster among women than men (up 37 percent in 1989), and thousands are passing the virus to their children through pregnancy, ushering in a new generation of sickness and despair. ☐ Joseph A. Riggs, MD

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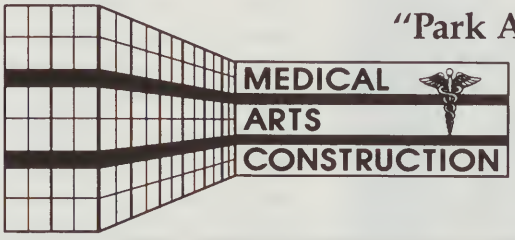
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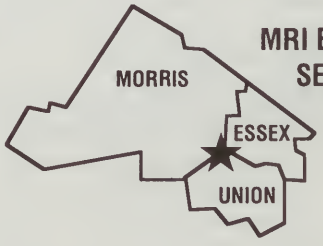
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Special Report: Video-Endoscopic Thoracic Surgery

Ralph J. Lewis, MD
Robert J. Caccavale, MD
Glenn E. Sisler, MD

Since the advent of video optics, with the projection of images on a screen, a new option has been added to the armamentarium of the thoracic surgeon: video-endoscopic thoracic surgery. A case report of a 33-year-old woman demonstrates the successful new procedure.

The technique of thoracoscopy has been known since 1910 when Jacobaeus inserted an electrically illuminated cystoscope into the pleural cavity.[1] In the past, this procedure was used for lysis of pleural adhesions, permitting the lung to collapse in the treatment of tuberculosis. Since the introduction of chemotherapy for tuberculosis in the 1940s, thoracoscopy has been utilized infrequently and almost exclusively for diagnostic purposes.[2] Thoracoscopy did not seem to have any significant therapeutic value.

With the recent development of video cameras, allowing transfer of images to a television screen, and compatible instrumentation, the authors evaluated this new technology for possible applications to video-endoscopic thoracic surgery.[3,4] The authors have been very encouraged and anticipate a major role for video-endoscopic thoracic surgery, with numerous therapeutic applications, in the field of general thoracic surgery.[5,6]

CASE REPORT

A 33-year-old woman was in good health until two years before admission when she developed fatigue, intermittent fever, nonproductive cough, and mild shortness of breath. There was no history of previous pulmonary infection, and no exposure to dust, asbestos, or cigarettes. Chest x-ray revealed bilateral pulmonary infiltrates and multiple bullae. Several courses of antibiotics and a short trial of steroids were unsuccessful. A recent bronchoscopy was negative. On physical examination, she appeared well developed and nourished. There was no cervical or supraclavicular adenopathy; her chest was symmetric with normal anterior-posterior diameter; lungs were clear but breath sounds were distant; cardiac examination revealed a regular rhythm without murmurs; her abdomen was without masses or organomegaly; extremities were without clubbing, cyanosis, or edema. All laboratory values were within normal limits.

The patient was offered video-endoscopic lung biopsy and ablation of bullae as an alternative to traditional thoracotomy. The procedure was performed using a Wolf 10 mm 0° Panoview Diagnostic Telescope®, Dyonics Model 5600 Camera® and Camera Head Dyonics Auto-Brite Illuminator II®, and a Dyonics Medical Grade Video Monitor®.

Anesthesia was administered through a double lumen endotracheal tube and the patient positioned in a lateral decubitus position. The right chest then was aseptically prepped and draped. The ipsilateral lung was collapsed. A stab wound was made along the posterior axillary line at the sixth intercostal space. The chest was carefully entered using blunt dissection. After confirming the absence of adhesions between the lung and chest wall by digital palpation, a 10 mm operating port was inserted, through which the diagnostic telescope was inserted. The entire right hemithorax was examined utilizing images on the video monitor. Along the anterior axillary line, two operating ports were similarly placed. Utilizing the operating ports and video camera, an appropriate portion of the lung was chosen for a biopsy, grasped by forceps, and circled with endoloop ligature. The ligature was securely tightened. The lung distal to the ligature was transected with scissors and the specimen removed through the operating port. The procedure was performed twice yielding two large specimens for pathology and microbiology. A large bulla then was visualized at the lung apex. The coagulating cautery was applied to the surface of the bulla for short intervals at various points along its surface. The coagulation decreased the size of the bulla. The lung then was re-

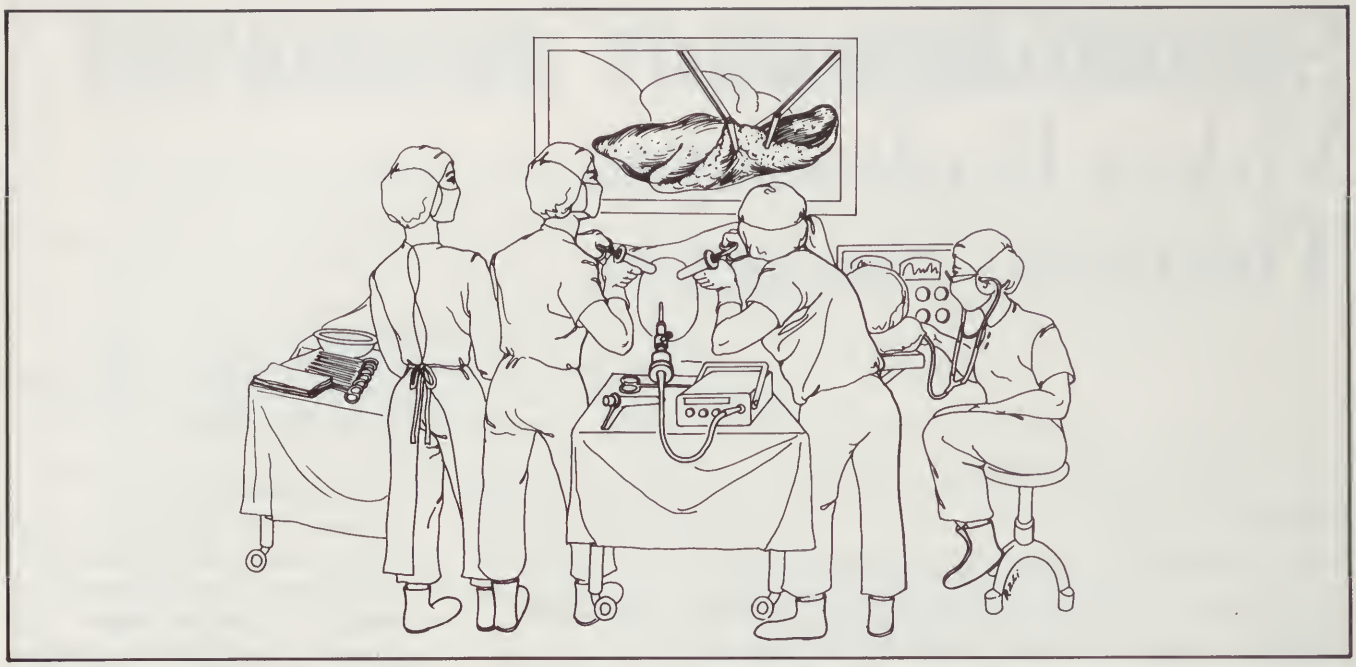


Figure 1. Technique of video-endoscopic thoracic surgery-lung biopsy.

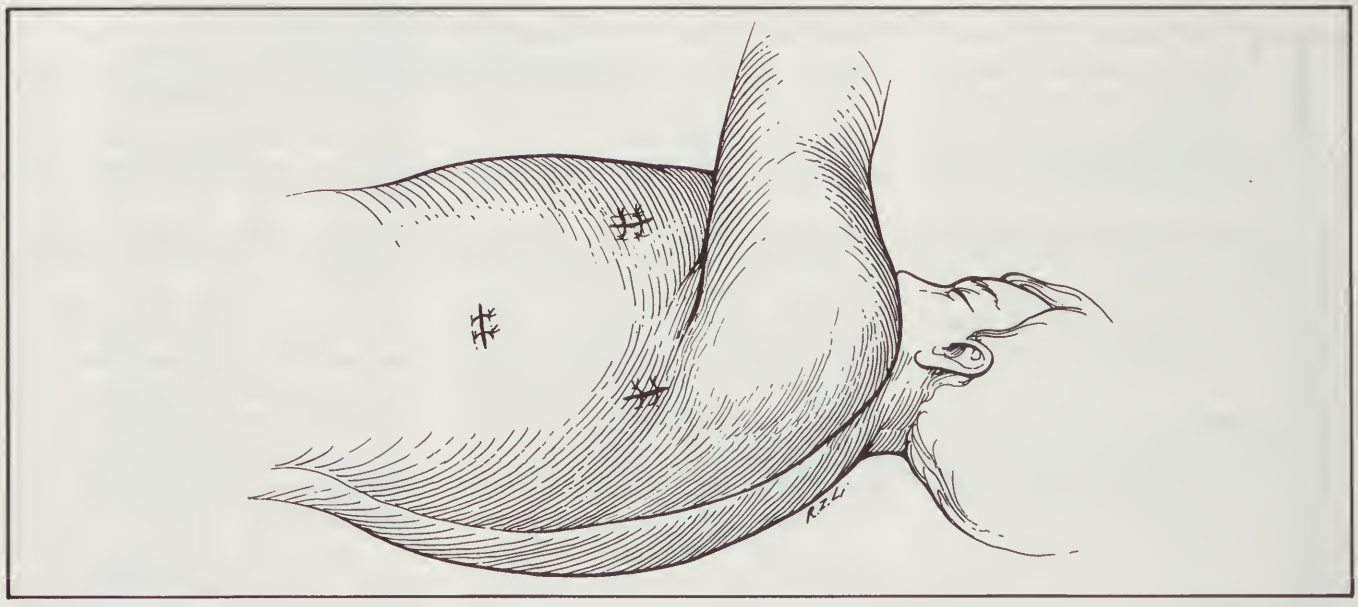


Figure 2. Wounds closed following video-endoscopic thoracic surgery-lung biopsy.

expanded and observed for air leaks and bleeding. The ports were removed, two chest tubes were placed and connected to underwater drainage, and all wounds were closed with interrupted absorbable sutures. The skin was closed with a running subcuticular stitch. In the recovery room, the patient was stable and had no air leak through her chest tubes. On postoperative day 2, the tubes were removed and the patient discharged to her home. The pathologist's examinations of the lung tissue revealed severe fibrosis with granuloma formation.

DISCUSSION

Thoracoscopy has been a procedure that excluded all assistants on the surgical team from participation, and the surgeon had very limited visualization and access to the intrathoracic structures. Since only simple diagnostic procedures could be performed, therapeutic applications were considered far beyond the realm of this technique. For these reasons, thoracoscopy never gained wide acceptance among thoracic surgeons.

With the advent of video cameras and their projected images, every area of the intrathoracic cavity became approachable. All members of the surgical team could visualize the surgery, and assistants could participate in the procedures. Since this new technique enables more complex procedures to be performed, it advances the applications from

purely diagnostic to therapeutic ones. Thoracic surgical problems previously requiring a major thoracotomy with its accompanying morbidity, mortality, and prolonged hospitalization now could be done efficiently and expeditiously, and with a remarkable reduction in pain and discomfort, by video-endoscopic thoracic surgery. As demonstrated by this patient, recovery was rapid and chest wall pain was not a problem. The lung biopsy specimens were obtained without difficulty and provided definitive microscopic findings. The bulla was readily accessible and easily ablated. This technique could have significant value for poor-risk patients who may not recover from the injury resulting from formal thoracotomy. Another group of patients who might benefit would be younger active patients. These relatively healthy patients might well refuse a major thoracotomy and open lung biopsy until symptoms became more debilitating. These same patients, however, might agree to a less invasive procedure, such as video-endoscopic lung biopsy, earlier in the course of their diseases when the potential for reversibility and complete recovery is greater.

Early diagnosis also could reduce or eliminate the need for many painful, inconvenient, costly, and nondefinitive tests used to evaluate the etiology of diffuse pulmonary infiltrates. Obviously, as instrumentation improves and techniques evolve, indications for video-endoscopic thoracic surgery will expand. In some of our subsequent patients, a 30 mm Ethicon RL 30 Proximate® stapler has been inserted into the chest through a 5 cm incision along the anterior axillary line and used for lung biopsy and excision of small peripheral tumors. This not only simplifies and expedites the procedure but achieves a more reliable lung closure. Similarly, the Birtcher® argon beam coagulator has been found to be superior to the cautery for bullous ablation. Currently, lung biopsy, excision of small superficial tumors, bullous ablation, treatment of recurrent pneumothorax, development of pericardial windows, and excision of mediastinal cysts have been performed using video-endoscopic techniques. Even lobectomy and pneumonectomy could be considered using this technique.

CONCLUSION

Video-endoscopic thoracic surgery permits an effective, safe, and expeditious procedure with early recovery and discharge for a patient. The impact on the field of general thoracic surgery could be profound. ■

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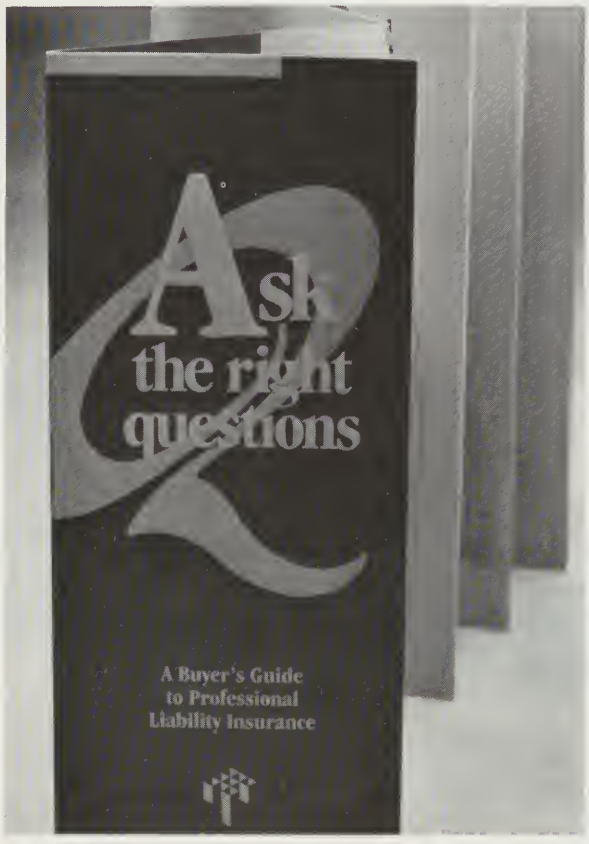
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A Surgeon Defends Himself in a Malpractice Trial

Peter P. Poulos, MD, JD

The author presents a case of disc escape without strut fracture in a Bjork-Shiley tilting-disc aortic valve. Two years after the patient's death, the surgeon, the valve company, the hospital, and others were sued. The surgeon, a first-year law student, represented himself, pro se, at trial.

This was an interesting case of disc escape without strut fracture in a Bjork-Shiley tilting-disc valve. Four years after the insertion of a prosthetic valve, the patient was reoperated on for a paravalvular leak. After the leak was repaired with two simple sutures, the patient could not be removed from extra-corporeal circulation. Re-exploration revealed a disc escape without strut fracture and a new prosthesis was implanted. The patient did not survive the prolonged procedure. Two years after death, the surgeon, the valve company, the hospital, and various Jane and John Does were sued for wrongful death. The author, the surgeon and a first-year law student at the time, engaged an attorney, dismissed him after three years in the discovery period, and represented himself, pro se, at trial. The surgeon countersued the plaintiff for conversion of the surgical fees.

THE CASE

In February 1982, a 54-year-old, diabetic, retired white male was admitted to the hospital for the third time. He complained of chest pain relieved by Nitro-Bid® and shortness of breath upon exertion; the clinical diagnosis was of aortic insufficiency, postaortic valve replacement.

This patient's first hospitalization was in 1975. Cardiac study revealed a transaortic pressure gradient of 50 mmHg, with a moderate amount of aortic insufficiency. The left ventricular end-diastolic pressure was 28 mmHg. Conservative therapy was recommended at that time, consisting mainly of digoxin, diuretics, diet, and rest.

The second hospitalization was in 1978. The study revealed a 91 mmHg gradient across the aortic valve with a left ventricular pressure of 203/15 mmHg, and a cardiac output of 2.5 L/min/m^2. Because of the increase in the transaortic gradient, replacement of the stenotic and incompetent, heavily calcified aortic valve was performed.

In February 1982, a cardiac catheterization showed a pulmonary wedge pressure of 25 mmHg, no mitral insufficiency, a left ventricular pressure of 137/37 mmHg, an aortic pressure of 136/61, and a cardiac output of 1.77 L/min/m^2. Cineangiography with injection of contrast material into the ascending aorta showed a severe amount of regurgitation into the left ventricle. There also was a major obstruction of the proximal posterior descending artery. The patient's case was presented at the medico-surgical conference where all agreed that an operation should be recommended to the patient and "probably all that will have to be done is to replace one or two sutures and not the whole valve."

Moreover, the patient requested a second opinion; arrangements were made by the patient's physician to consult with an eminent New York cardiac surgeon. Apparently, the patient decided he would not have the second opinion, but would have the surgical correction of the incompetent aortic valve at the hospital. Preoperatively, a consultation was requested of the cardiologist, who, possibly, would assist in postoperative support by insertion of an intra-aortic balloon pumping device.

THE OPERATION

The patient signed an informed consent to "repair or replace the aortic valve and coronary artery bypass to the right coronary." Eight units of properly matched blood, seven units of platelets, and ten units of fresh frozen plasma were ordered for possible use in the operating room in March 1982.

The incision was through the previous mid-sternotomy; the mediastinal tissues were separated by a combination of sharp

and blunt dissection. Although this took some time and considerable patience, there was relatively little blood loss. The right femoral artery and the right atrial appendage were cannulated for the extracorporeal bypass. General body heparinization was established. A vent catheter was placed in the right superior pulmonary vein and its tip was advanced into the left ventricle.

The systemic vein used for the coronary bypass was obtained from the great saphenous continuation between the right ankle and the knee. Its proximal (cephalic) end was joined to the poststenotic portion of the posterior descending branch of the right coronary artery in the usual oblique end-to-side fashion. The distal end of the vein was injected with heparin solution and was kept cross-clamped until needed for coronary perfusion of cardioplegic solution.

The patient was cooled by establishing extracorporeal circulation and using the heat exchanger until the body temperature was 25°C to 26°C. The ascending aorta then was cross-clamped and a cardioplegic solution was injected into the supravalvular portion, while manually compressing the left ventricle, and into the right coronary artery by way of the bypass graft.

The supravalvular aorta was opened transversely just proximal to the previous site of the aortotomy (also having been made transversely). There was a paravalvular leak behind the posterior aortic cusp measuring 8 to 9 mm in length and 4 to 5 mm in width. This was repaired promptly by passing the double arms of two mattress sutures through the prosthetic sewing ring and completely through the aortic wall. The ends were tied externally over pledgets of Teflon® felt.

The aortotomy was repaired with a running suture of #3-0 prolene buttressed with Teflon® felt. The left ventricle and the ascending aorta were vented of all contained air and the aortic crossclamp was removed.

Extracorporeal circulation with the heat exchanger was maintained until the patient had been rewarmed to 32°C to 33°C. The patient's heart commenced to beat spontaneously and, as its vigor become marked, the extracorporeal bypass was slowed and terminated. A portion of the blood in the reservoir was returned to the patient and it appeared that no additional blood or blood products would be necessary.

The charge nurse or a member of the perfusion or anesthesia team appears to have informed representatives of the blood bank that none of the previously ordered blood would be needed. Hence, that blood was released and used for another patient.

However, the patient's condition soon began to deteriorate and the cardiologist was asked to consider the insertion of an intra-aortic balloon assist device. He noted an extremely low diastolic pressure on the monitor. The surgeon felt the aorta over the region of the prosthetic valve and was unable to feel the characteristic vibration (clicking) of the functioning valve.

The extracorporeal bypass was reinstituted and the patient was recooled. The aorta was cross-clamped and cardioplegic solution was reintroduced. Then the aortotomy was reopened.

The valve poppet, the disc, was gone. Exploration of the left ventricle failed to disclose it. Later radiographic examination of the abdominal aorta revealed its presence just above the bifurcation but in no way obstructing blood flow.

The old prosthetic valve was grasped and pulled by a Kocher clamp, the attaching sutures were cut, and the valve was rapidly removed. Another #23 Bjork-Shiley aortic prosthesis of identical type was held in the appropriate holder and commissural and intercommissural mattress sutures were rapidly placed between the sewing ring and the aortic wall. The prosthetic valve was advanced into the aortic orifice and the sutures were securely tied.

The ventricle and ascending aorta were vented of entrapped air, the aortic crossclamp was removed, and the patient was rewarmed.

Cardiac contractions commenced spontaneously and the extracorporeal pumping was discontinued. The blood pressure rapidly assumed a level of 120/70 mmHg.

However, bleeding from all cut or dissected surfaces now became very marked. Undoubtedly, this was related to the excessive period of extracorporeal circulation (two periods of extracorporeal circulation: 1 hour and 44 minutes and 2 hours and 25 minutes, respectively, including the prolonged period of resuscitation). Such a long bypass damages the factors related to blood coagulability and requires the administration of extra blood products, especially whole blood (or packed cells) for this and for other patients.

Unfortunately, since the original crossmatched blood had been released upon the conclusion of the first period of bypass, it now was necessary for new blood to be crossmatched and prepared.

This blood preparation took 45 minutes during a period of acute need by the patient. Various supportive measures such as reinstitution of extracorporeal circulation, the administration of cardiotonic and vasopressive drugs, the institution and effectuation of intra-aortic balloon pumping (assistance to cardiac output), and the anastomosis of the upper end of the right coronary arterial bypass graft to the ascending aorta all proved ineffective. Circulation could not be maintained and the cardiac contractions weakened and ceased. Death was pronounced.

THE CLAIM

On February 1984, just short of the two-year statute of limitations,

I received the complaint and jury demand naming me, Shiley Inc., the anesthesiologist, the hospital, and various Jane and John Does as defendants. The claim, filed by the patient's wife as administratrix of the estate of the patient, charged that some of the defendants failed to order, maintain, and ensure the availability of properly matched blood; the defendants' negligence was a substantial contributing factor in the death of the plaintiff; the surgeon deviated from accepted standards of medical care; and Shiley Inc. placed a defective product on the market.

The complaint was sent to my insurance company, and I discovered that I had no coverage for the period in question; I had to find a lawyer. I worked with my lawyer for about three years, through a long and tedious discovery period. Then, I was told that my case could be settled for about $25,000. I was upset because legal fees to date were about $30,000 and there was never any intention of settling the case at a cost of $25,000. I authorized a settlement of $20,000, and the additional trial costs. Luckily, the plaintiff refused my offer. I then decided to dismiss my lawyer and represent myself, pro se.

Why fire the lawyer and represent myself? There were many reasons for my action: an attempt at settlement should have been made much earlier; I felt my lawyer never understood the problem of the loss of a disc without a strut fracture in the Bjork-Shiley valve; I never felt my lawyer believed I was not guilty; and the technical problems of open-heart surgery with valve replacement were too difficult for the lawyer to understand and explain to the jury. I had been explaining intricate open-heart surgical operations to patients and relatives for 30 years and no one could do so better than I in presenting the surgical procedures to a jury. I felt then, and know now, that the side with the most technical knowledge would win the case.

PREPARATIONS

Four months before the trial, I started the first year of Rutgers Law School. Although the course in torts helped me understand the meaning of negligence and the course in contracts helped me understand breach of contract, the law library and access to videotapes were helpful. In particular, a video, "The Advocate" (Training Video TTA1-01), proved most helpful. It depicted the trial of Doyle versus Power Co., and explained the various elements of a trial: jury selection; voir dire; opening statement; laying the foundation; exhibits; authentication; relevance; heresay rule; steps in introducing an exhibit; lay witness; expert witness; direct examination; cross-examination; introduction of demonstrative evidence; closing argument; and jury deliberation. I learned more about trial advocacy by studying the tape than I did in three years of law school courses.

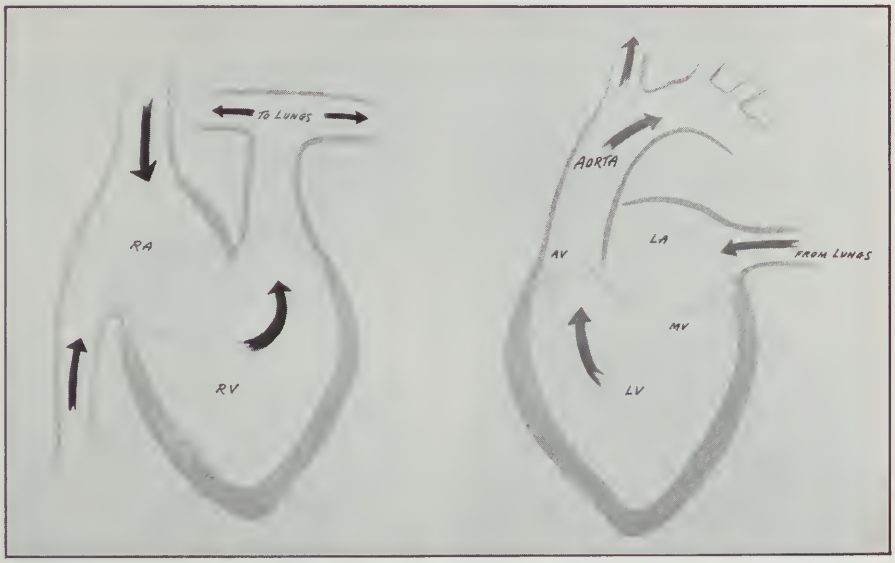


Figure 1. Structure and function of the heart.

EXPERT WITNESSES

I asked six local thoracic surgeons to be my expert witnesses. Fortunately, they all refused because they either did not have time or did not wish to oppose the cardiologist who was testifying that the attempt to repair a paravalvular prosthetic leak was a disaster, never should be done, and the valve always should be replaced. It became difficult to find a thoracic surgeon who did understand the problem of disc escape without strut fracture.

I did obtain the world's outstanding cardiac surgical pioneer, Charles P. Bailey, MD, JD, as my cardiac surgical expert. Dr. Bailey submitted a very scholarly and comprehensive opinion, part of which follows:

The unfortunate decedent has been properly submitted to surgical replacement of a heavily calcified aortic valve four years previously. Although that operation had been well tolerated, evidence of a paravalvular leak had become increasingly evident. Such leaks are prone to occur with heavily calcified valves. Thereafter, the patient's clinical condition had deteriorated with evidence of developing coronary atherosclerosis (obstructive), enlargement and hypokinesis of the left ventricle, elevation of the end-diastolic pressure within the left ventricle, and serious reduction in the resting cardiac output (and index). These latter signs are indicative of a serious loss of cardiac reserve, undoubtedly constituting a significant element of congestive heart failure. Moreover, the patient's diabetes mellitus and his undisciplined lifestyle augured for a relatively short life expectancy.

In the hope of arresting or slowing this progressive clinical deterioration

it was agreed at the medico-surgical conference of February 24, 1982, that surgical correction of the paravalvular leakage was indicated even though it was realized that the patient was far from an ideal candidate for such major surgery. A second surgical opinion was arranged (although not followed through by the patient).

At the time of surgery a limited paravalvular leak was identified. It was almost an ideal one for surgical repair and this was accomplished expeditiously with the placement of two buttressed mattress sutures. Undoubtedly, if nothing inadvertent had intervened the patient would have presented no further evidence of valvular insufficiency. Of course, he still would have had his diabetes, his coronary arteriosclerosis, and his left ventricular (myocardial) degeneration.

Unhappily, as soon as the cardiac contractions became excessively vigorous after interruption of the extracorporeal circulation (the first time) the dynamic effect upon the Bjork-Shiley prosthetic valve was sufficient to 'bend' the struts sufficiently to permit the strut-poppet, or strut-disc, distance to increase beyond the 0.038 inch which the company engineers calculate are necessary to permit the poppet to escape. During the two-year period of 1982 to 1984 there were 76 reported examples of actual strut fracture in Bjork-Shiley valves which are claimed not to have been altered structurally since their introduction in 1969. In each of these cases the poppet escaped. More recently, there have been 17 reported examples of poppet escape without strut fracture. Although the manufacturer has postulated that some of these episodes might have been due to the surgeon 'bending' the struts and then 'bending' them back, that would appear to be ludicrous since they have taken place anytime from a few minutes to four years after emplacement. And always the strut-poppet distance has been below 0.038 inch when measured. Undoubtedly, hemodynamic changes which take place in the valve must be explanatory of these otherwise 'impossible' poppet escapes. And about the only way the heart and vascular circulation could impose such dynamic stresses would seem to be by extreme alterations in the blood pressure or the violent beating of the heart as is often seen when coming off an extracorporeal bypass. No doubt these stresses can actually 'bend' the struts, at least momentarily.

Unfortunately, when the patient seemed to have survived the planned procedure so unexpectedly well, the blood and blood products which had been immediately available for him were released to the advantage of some other individual who no doubt was also in urgent need of them. Unhappily, when the patient desperately needed that blood after his coagulation mechanism had been disrupted by the second episode of extracorporeal cirulation there was none to be had for what seemed to the attendings to be an inordinately prolonged period. And when the blood did come, the much deteriorated and overtaxed myocardium was no longer able to respond.

It is undoubtedly true that some surgeons would have replaced the prosthetic valve initially rather than repairing it. However, those with greater experience almost always would choose direct suture repair of a paravalvular leak of limited size as this one was. In a more extensive detachment of the valve, replacement, of course, would be indicated. But here, the application of two mattress sutures, rather than the 12 to 20 required for a total valve replacement ordinarily would have enabled a prompt and effective termination of the procedure in this patient who was thought barely to have enough reserve to sustain even that. The medical literature is replete with reports of the profession's preference for repair of paravalvular leaks when they are of limited size over total valve replacement.

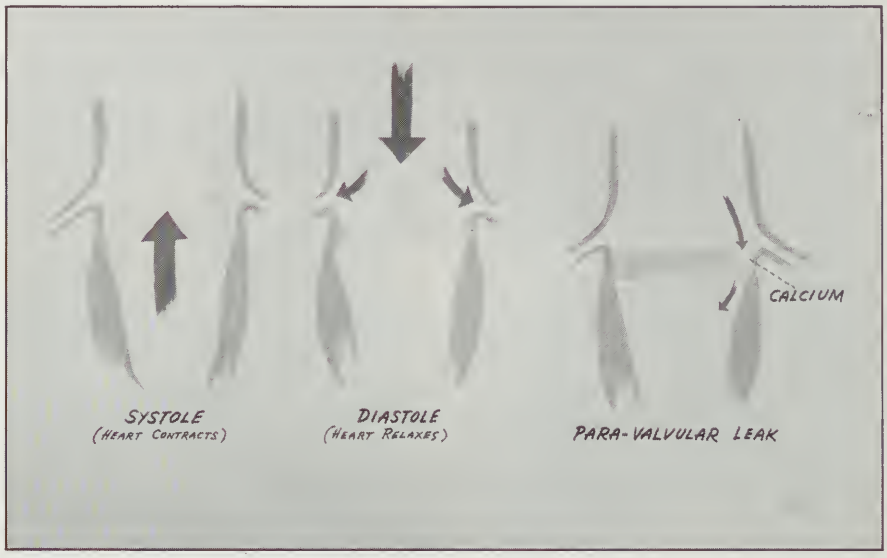


Figure 2. The aortic valve and a paravalvular leak.

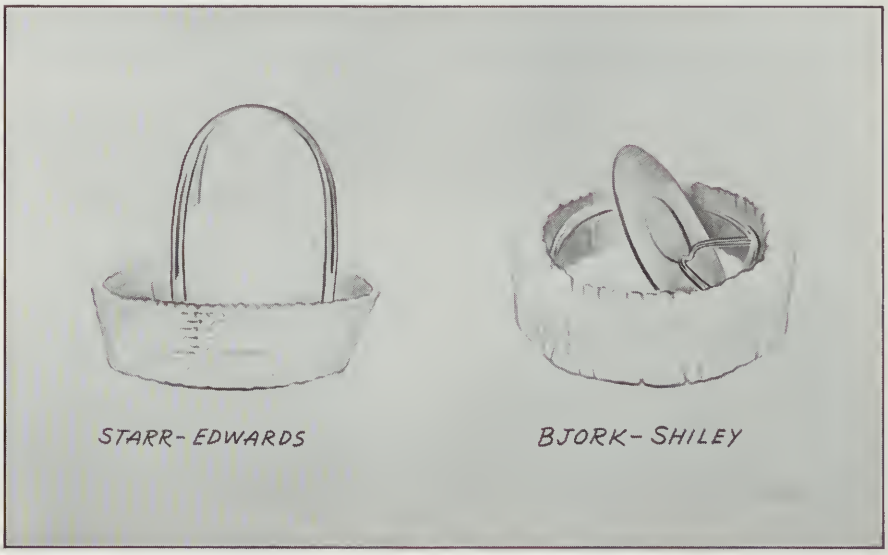


Figure 3. A ball-cage valve compared to a Bjork-Shiley valve.

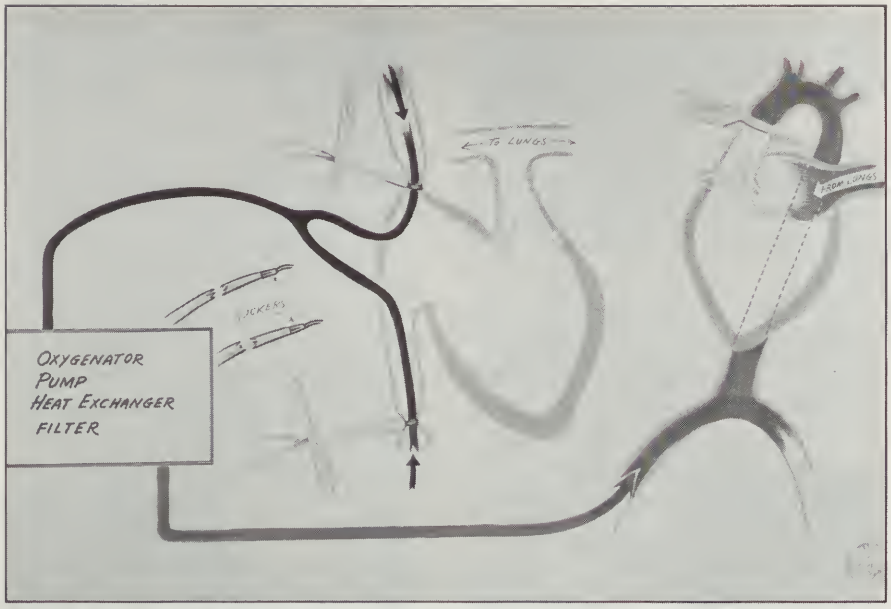


Figure 4. The heart-lung machine used for aortic valve replacement.

In summary, Dr. Poulos used exemplary skill and judgment in the management of this unusually high risk case where corrective surgery had become mandatory. Except for the extremely unfortunate coincidence of the unforeseeable escape of the valve disc, the patient would surely have survived from this rather quick and simple procedure. Whether this man with his much degenerated myocardium would have survived if the longer and more taxing total replacement of the valve had been carried out initially is questionable.

However, the necessity for the two operations with the consequently much prolonged total bypass time and the delay in the blood replacement after the second episode of circulatory bypass proved to be too much for his weakened heart.

ENGINEERING REPORT

I was able to obtain a biomedical engineering expert, Jesse F. Crump, MD, who had an engineering degree from the University of Nebraska, and was an associate professor of bioengineering at the Polytechnic Institute of Brooklyn. He submitted an opinion based upon the medical literature relating to the Bjork-Shiley valves; Federal Drug Administration (FDA) factory inspection reports of Shiley laboratories; interviews with the surgeon; and review of Shiley product complaint reports. In an opinion dated November 19, 1985, Dr. Crump stated: "There is substantial evidence that the Bjork-Shiley tilting-disc valve, in general, always has been prone to several problems, among which, the most serious has been strut fracture failures, strut bending, and disc escape."

INSPECTION REPORTS

Through the Freedom of Information Act, the following was obtained: As early as July 2, 1973, an FDA Establishment Inspection Report (EIR) stated that there was a percentage of complaints involving defective struts that allowed the disc to slip out.

Again on August 26, 1975, an EIR was conducted because of valve failure reports and the firm recalled all the remaining valves from those lots.

An EIR of February 22, 1980, indicated that 2,889 valves were recalled, because Dr. Bjork had implanted a valve in March 1978, and the patient died in November 1979. Analysis of the valve revealed that failure was caused by strut fracture due to metal fatigue. The report further stated, "Engineering evaluations are not performed routinely on product line valves."

An EIR on February 8-12, 1982, stated that the inspection showed eight additional valves have failed due to fractures, since the recall in 1980—including valves made before and after the recall.

An EIR on May 14, 1982, stated that Shiley had initiated a voluntary recall of all unimplanted 29, 31, and 33 mm 60° valves manufactured between May 1980, and February 1982, because of strut fractures. The firm developed a miniaturized strain gauge to determine stresses in the outlet strut. The idea was to eliminate valves subject to downstream strut fractures. Shiley was willing to replace all valves made prior to May 1980.

An EIR on March 15, 1983, concerned the quality control procedure for the load deflection tests. All valve fractures occurred at the same location on the outflow welded strut. Setting the hook (outflow strut) relative to the disc was found to be variable and some struts received more up-down manipulation than other struts.

On July 6, 1983, Shiley recalled all 60° valves of 29, 31, and 33 mm because of strut fractures. All 3,963 valves were manufactured between February 1981, and March 1982. The strut fracture rate was higher in this group than before February 1981. The recall letter stated, "Shiley had decided to recall these valves because they represent a higher potential of strut fracture than valves welded since March 1982."

In order to understand the problem of disc escape without strut fracture, during the discovery period, Shiley produced 18 product complaint reports of disc escape without strut fracture. The following comments were based on these reports:

1. Report #0279123-1. December 3, 1979, from Munich, Germany: The disc slid out of struts under intraoperative conditions. The surgeon had to explant the valve and replace it. For that reason, the operation was of very long standing and the patient died on the operating table. The surgeon did not use any holders or instruments while sewing in the valve. He used a finger-hold-

ing technique. This operation was performed by the best surgeon in the hospital.

Findings by Shiley were deep gouges and scratches all over the rim and strut. The disc-to-strut "distance was enlarged from .021 inch when shipped to .041 inch on return."

Comment: Although the surgeon specifically stated he held the valve in his fingers, Shiley implied scratches on the rim and strut had somehow increased the disc-to-strut distance and the disc escaped. The most reasonable explanation is that the marks on the rim and struts were made in explanting the valve from the patient, and not while implanting the valve.

2. Report #CV81-024. April 10, 1981, from Lyon, France: A 3-year-old patient died on postoperative day three. Autopsy showed the disc absent from the aortic position. Also, a 51-year-old patient had his mitral valve replaced. In the recovery room, he developed shock and was rushed back to the operating room. The disc was found in the ventricle. In returning the valve, the report stated, "You will find scratches on the ring and struts because the surgeon used clamps during the explantation."

Findings by Shiley: Scratches on the valve cage and disc-to-strut distance increased from 0.02 inch on shipping to 0.032 inch on return. But the 0.032 inch measurement should not allow the disc to escape. Therefore, Shiley speculated that "the disc dislodgement occurred during in vivo cycling."

Comment: This is a very instructive case. The static measurement of 0.032 inch indicated that the disc should not escape, but under dynamic (blood flow) conditions the disc does escape.

3. Report #C-69-4. September 28, 1979, from Czechoslovakia: This was called the flying-disc by the surgeon. The valve was implanted on May 6, 1979, and explanted on May 8, 1979.

Findings by Shiley: The disc-to-strut distance was 0.011 inch on shipping and 0.021 inch on return. No scratches or marks on the rim or struts were reported.

Comment: Same case as #2. The static measurement of 0.021 inch should never allow the disc to escape, but under dynamic conditions, the disc did indeed escape.

4. Report #93-136-95. May 16, 1983, from Czechoslovakia: The disc was found lying loose within the container. The valve never was used and returned.

Findings by Shiley: The disc-to-strut distance was 0.19 inch on shipping and 0.23 inch on return. This would not allow, in and of itself, the disc to escape. Shiley speculated that the container was opened, the struts bent open, the disc removed, and the struts pushed back.

Comment: A most unlikely explanation. The most probable explanation is that the disc was distorted or the tolerances were incorrect. Why not test for disc distortion?

5. Report #CV80-048. May 8, 1980, from Kuwait: The disc escaped on the table after complete insertion with minimum manipulation.

Findings by Shiley: Disc-to-strut distance was 0.22 inch on return. This would not allow the disc to escape.

Comment: Same as case #4, probable disc distortion that was not tested.

6. Report #84-132-02. May 11, 1984, from London: The disc fell out during surgery.

Findings by Shiley: There were tool marks and scratches on the valve. The disc-to-strut distance was 0.016 inch on shipping and 0.032 inch on return. This would not allow the disc to escape. Shiley speculated that the struts were bent open, the disc escaped, and then the struts were bent back.

Comment: Most likely same reason as #4 and #5, disc distortion, that was not tested and if tested, was not reported.

7. Report #84,10201. May 17, 1985, from Holland: The disc escaped during rotation. The surgeon stated he always put the Bjork-Shiley valve in the designated holder and, further, the scratches on the middle part of the large strut were caused during the removal of the valve.

Findings by Shiley: There were tool marks and scratches on the valve and the disc-to-strut distance was 0.017 inch on shipping and 0.043 inch on return. This last measurement is greater than 0.038 inch and would allow the disc to escape.

Comment: This case demonstrated that the surgeon can follow the manufacturer's instructions, use the holder to rotate the valve, and still the struts can be bent without negligence on the surgeon's part.

8. Report #CV81-022. November 1977, from France: A valve was implanted November 1977, and removed March 1981, on an emergency basis for disc dislodgement.

Findings by Shiley: The disc was free but could be "snapped" back into place. The disc-to-strut dimensions were "within tolerances" but not given. Shiley could not explain the escape of the disc.

Comment: Shiley cannot explain the disc escape on the basis of "static measurements," but under in vivo, dynamic conditions there is a simple explanation. Hemodynamic forces that cause the struts to fracture will cause the struts to bend, yield, and allow the disc to escape.

9. Report #83-178-01. June 27, 1983, from England: An 11-year-old boy was operated on May 5, 1983, reoperated on, and died on May 13, 1983. X-rays showed the disc free in the ventricle but at reoperation the disc was back in the struts.

Findings by Shiley: Showed a disc-to-strut distance of 0.021 inch on shipping and 0.023 inch on return. This would not allow the disc to escape. Shiley speculated that the struts were opened, the disc escaped, then the struts bent back before returning the valve.

Comment: Static measurements prove nothing. Dynamic conditions are the answer. Shiley's speculation does not make sense.

10. Report #84-151-01. May 5, 1984, from Columbia: A disc fell out directly after implantation.

Findings by Shiley: The disc could be removed from the flange with little pressure; and Shiley did not report disc-to-strut distances, because this was not the problem. Shiley speculates that the struts were bent open and the disc escaped.

Comment: If the struts "were bent open" and the disc escaped, then the struts yielded, elastically, and returned to within tolerances. This most probably is what happens under dynamic conditions.

11. Report #83-48-01. February 14, 1983, from Charlotte, North Carolina: Postoperative day one, a patient developed arrhythmias and low cardiac output. X-rays showed the disc in ventricle. At reoperation, the disc was back between the struts.

Findings by Shiley: Scratches existed on the valve, the inlet strut was bent, and the disc-to-strut distance was 0.017 inch on shipping and 0.028 inch on return. This would not allow the disc to escape "because the disc-to-strut distance should be over 0.038 inch." Shiley speculates that somebody widened the strut, allowing the disc to escape and to return, then bent the struts back into position.

Comment: Dr. Robicsek first sent the valve to an independent testing laboratory before returning the valve to Shiley. Shiley's speculations are not reasonable. The escape of the disc can be explained easily on the basis of dynamic measurements that Shiley repeatedly has failed to perform or report.

12. Report #82-214-04. August 2, 1982, from Chicago, Illinois: The surgeon could not get the patient off the pump. The heart was reopened and the disc was lying free.

Findings by Shiley: There were scratches on the valve and the disc-to-strut distance was 0.014 inch on shipping and 0.036 inch on return. Shiley stated in the report that the 0.036 inch was "far beyond the maximum allowable."

Comment: Shiley's statement that 0.036 inch was "far beyond the maximum allowable" is not true. Shiley's letter to Dr. Robicsek (report #11) stated that in order for the disc to escape, the disc-to-strut distance must be greater than 0.038 inch."

13. Report #0279113-1. November 13, 1979, from the Philippines: The mitral disc escaped after implantation was completed. The patient still was on the pump, and the valve was replaced.

Findings by Shiley: There were scratches on the valve and the disc-to-strut measurements were 0.022 inch on shipping and 0.032 inch on return.

Comment: These static measurements indicated that the disc should not escape, but it did under dynamic conditions.

14. Report #83-236-02. July 6, 1983, from Turkey: The mitral valve disc escaped during implantation.

Findings by Shiley: Scratches were present and the disc-to-strut distances were 0.019 inch on shipping and 0.031 inch on return. Shiley speculated that the struts were bent open, the disc escaped, then the struts were bent closed before returning.

Comment: Shiley's speculation is not reasonable. One must consider disc distortion, strut distortion, or both.

The four remaining reports were similar to the others.

RECALLS

On October 14, 1985, Shiley recalled all 29, 31, and 33 mm Bjork-Shiley 60° convexo-concave valves because of the high rate of strut fractures. Shiley will focus its attention on the mono-strut valve, and still manufacture the smaller size Bjork-Shiley valves.

In November 1986, all unimplanted 21, 23, 25, and 27 mm Bjork-Shiley convexo-concave valves were recalled.

THE CASE IN QUESTION

The specific purpose for describing the major problem of strut fracture and disc escape is to emphasize the significant hemodynamic forces present within the body, capable of fracturing the struts of the Bjork-Shiley tilting-disc valve. These same dynamic forces that are capable of fracturing the struts certainly can bend the struts in vivo, and allow the disc to escape. All metals yield before they break.

Product complaint reports #2 to #14 showed that the disc-to-

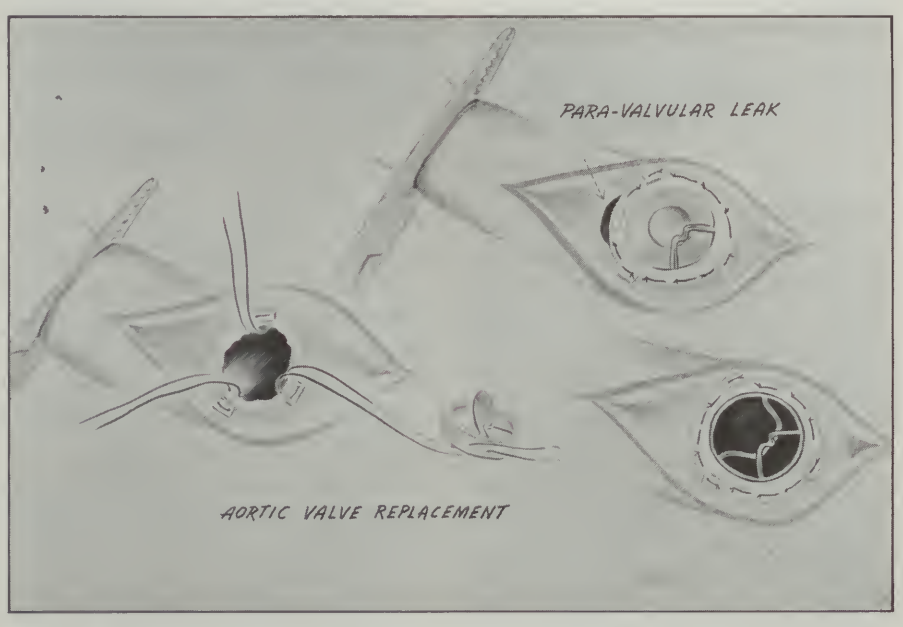


Figure 5. An implanted aortic valve and a repaired paravalvular leak.

strut distance was less than 0.038 inch, and, thus, the disc should not escape, but the disc, in fact, did escape. The answer is that disc escape cannot be explained by Shiley's measurement of static distances. Under hemodynamic in vivo conditions, the disc-to-strut distance increases and, thus, the disc escapes. This is the most logical and most reasonable degree of medical and engineering probability.

To speculate, as Shiley has done, that the surgeons from Germany, France, Czechoslovakia, Kuwait, London, Holland, Columbia, North Carolina, and Chicago bent open the struts allowing the disc to escape, and then bent the struts back together does not seem reasonable.

PRESSURE GRADIENT AND VALVE FAILURE

In the 1982 article, "Bioengineering Aspects of Heart Valve Replacement," Drs. Shoen and Titus have shown that mitral prostheses fail more frequently than aortic prostheses. While the reason for this difference is not clear, this distribution follows the same order as the maximum pressure gradients sustained by the valves during the closed portion of the cardiac cycle. During systole, mitral, the pressure gradient, is 90-120 mmHg. During diastole, aortic, the pressure gradient, is 60-80 mmHg.

This gives credence to the statement that there are significant hemodynamic forces that may break or bend, elastically or plastically, the struts of the Bjork-Shiley tilting valve and allow the disc to escape. For example, recall Dr. Robicsek's case in North Carolina (report #11). The disc repeatedly left and re-entered the struts. Measurements of the disc-to-strut distance was less than 0.038 inch and, thus, the disc should not escape—but it did escape.

SHILEY'S REPORT

As far back as 1973, Shiley found it convenient to blame surgeons for complaints involving defective struts that allowed the disc to escape. In the July 2, 1973, EIR, Shiley claimed all reported failures were caused by "user abuse" evident by clamp marks. The inspector reported, "In these cases, Shiley was able to show through inspection of the returned heart valves, such things as clamp marks on the struts which showed that the struts were damaged by the physician or his assistants."

Shiley's plan for defense has not changed.

A report on the valve in question stated there were multiple sites on the orifice ring and struts that have tool marks consistent with that made by an instrument with a serrated edge. The outlet strut was bent. There are numerous illustrations showing tool marks, stress marks on the rim, and on the struts at many sites.

It is obvious that most of these tool marks only can be made in removing the valve and when the disc is not in place. This is especially true with respect to the marks on the rim. These rim marks only can be made in removing the valve and when it is not attached to the aortic wall.

To find marks, scratches, and tool marks on the valve means nothing unless one can prove when and how the marks were made.

Many of the product complaint reports contained statements from the surgeons that tool marks were made when removing the defective valve.

EXHIBITS

The jury had to understand the anatomy and physiology of the heart, the function of the aortic valve, the construction of the Bjork-Shiley tilting-disc valve, how the heart-lung machine was used for open-heart surgery, how a prosthetic valve was implanted, and how a paravalvular leak was repaired. Since I had been an instructor in physiology at Cornell University Medical College and had 30 years of experience in explaining cardiac operations to patients and relatives, there was little doubt that very few lawyers could do as well as I could in this regard.

I was fortunate that my wife, a professional artist, was able to illustrate the structure and function of the heart; how the aortic valve works and diagram of a paravalvular leak; ball-cage valve and comparison with a Bjork-Shiley valve; how a heart-lung machine was used for an aortic valve replacement; and implantation of artificial aortic valve and paravalvular repair (Figures 1-5). From these explicit illustrations, the jury understood exactly why it was expeditious to place two simple mattress sutures in order to repair a small paravalvular leak rather than to remove all the old sutures and implant a new valve with 16 to 20 new sutures.

Explaining the rationale of the surgical procedure was very important because the plaintiff's expert witness testified that it was a mistake to attempt to repair the leak rather than replace the valve.

PLAINTIFF'S EXPERTS

The plaintiff presented a "Study of Economic Loss" by a professor of economics purporting to show the present value of the pecuniary loss suffered by the administratrix, the wife, as a result of the death of the patient as $137,262. The main deficiency of the report was that the economist obtained his data from the administratrix and failed to review the income tax returns of the plaintiff and wife.

I was able to obtain, by subpoena, the plaintiff's tax returns for 1979 through 1983, and constructed a table showing, conclusively, that as the result of the husband's death the wife's income actually increased by approximately $4,500 per year.

As the economist left the court room, he was overheard saying to the administratrix, "Why did you lie to me?"

The plaintiff's thoracic surgical expert, a surgeon from New York

1. On May 31, 1978, for replacing a heart valve, my charge was $3,000. Blue Shield sent $1,125 directly to me. The patient told me there was no other insurance. Prudential paid $1,547.86 of my fee to the wife and she kept it.

Before someone raises the question of the statute of limitations in this case, I believe that the discovery rule applies. I discovered the conversion as of the date of the Prudential letter, November 14, 1986, and suspected the conversion about five months ago.

2. On March 29, 1982, for removing and replacing a heart valve my charge was $4,500. Blue Shield sent me $1,575. Prudential paid $2,925 of my fee to the wife and she kept it.

Thus, I believe that the wife fraudulently converted at least two fees—$1,547.86 and $2,925 for a total of $4,472.86.

My argument is pure and simple. It is clearly understood, that when a patient agrees to allow a surgeon to perform an operation, a firm contract has been made between doctor and patient, or the patient's representative, and that the patient, or the patient's representative, promises to pay the fee. In these cases the surgeon kept the promise and performed the operations. The patient, or his representative, breached the promise and, without the doctor's knowledge, applied for, received, and kept a major portion of the doctor's fee. In view of the understanding that the doctor would be willing to accept only what the insurance would pay, the patient or the patient's representative fraudulently converted the doctor's fee.

Figure 6. A portion of the letter sent to the judge requesting the restitution of fees.

City, failed to appear and testify at trial, although he had been deposed at an earlier date. I agreed to have his deposition read at the trial. Particularly, the portion of his testimony where he stated, "Dr. Poulos failed to order enough blood for the operation." When asked how much blood Dr. Poulos did order, he said, "I don't know." No wonder he did not appear for the trial.

COUNTERSUIT

When I had an attorney, I repeatedly told him the plaintiff breached our contract, collected the major medical portion of the surgeon's fee, and kept the money. I was advised, legally, not to take any action because I would look bad and greedy. I could never understand this because it was the plaintiff who stole the fee. After I took over the case, I applied for the restitution of the doctor's fee (Figure 6).

JUDGE CHARGES JURY

After a three-week trial, the judge ordered "the restitution of the converted fees to Dr. Poulos," approximately $5,400 including interest on the money converted, and instructed the jury in deciding whether or not the surgeon was negligent or liable for damages.

The following questionnaire was submitted to the jury by the judge:

1. Did Dr. Poulos deviate from the accepted standard of surgical practice in electing to repair the area of the valve in question rather than replace the entire valve in the first operation? Yes____ No____

If the answer to the above question is "Yes," answer the following question. If the answer is "No," go to Question #3.

2. Was such deviation a proximate cause of the death of the patient? Yes____ No____

3. Was Dr. Poulos negligent in the manner in which he handled the valve in the first operation on March 29, 1982, damaging same and causing the condition which allowed the poppet to escape? Yes____ No____

4. If the answer to Question #3 is "Yes," was that negligence a proximate cause of the death of the patient? Yes____ No____

5. If you have answered Questions #1 and #2 "Yes" and/or Questions #3 and #4 "Yes," what sum of money would fairly, reasonably, and adequately compensate [the plaintiff] for damages and losses? $_____

6. If you have decided against Dr. Poulos, answer the following question:

Was there a defect in the valve which defect was a proximate cause of the death of the patient? Yes____ No____

If you have answered Question #6 "Yes," you must assess the percentage of liability of the valve company and Dr. Poulos.

Dr. Poulos_____%
Shiley Co._____%
100%

After 20 minutes of deliberation, the jury unanimously voted "No" for Questions #1 and #3. I was found not guilty.

The Shiley, Inc. settled the case on the first day of trial. ■

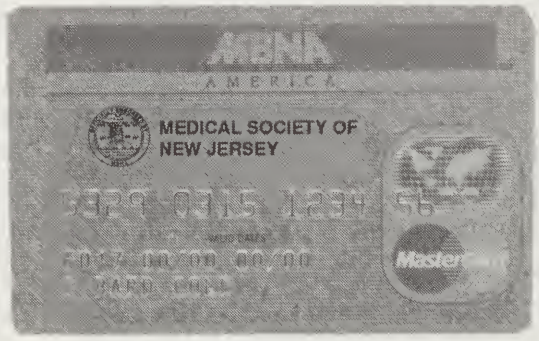
Dr. Poulos is a clinical professor of surgery, UMDNJ-Newark. Address requests to Dr. Poulos, 17 Maple Terrace, Maplewood, NJ 07040.

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Part II: Basic Approach to Health Screening

David E. Swee, MD
Laura Micek-Galinat, MD, MPH

Given the context and criteria for health screening in Part I, Part II raises various questions in assessing particular health screening recommendations. These questions then are applied to some of the very current controversies in health screening.

In Part I, we discussed a basic approach to health screening in terms of its historical context and addressed barriers to such screening. We summarized the basic criteria for screening that were developed during the 1970s and 1980s, classifying them into three major areas of concern: characteristics of the disease; characteristics of the populations to be screened; and characteristics of the test. In Part II, we will raise specific questions that should be answered in assessing particular screening recommendations and apply these questions to some current controversies in health screening.

SPECIFIC QUESTIONS

The following six questions need to be answered regarding a screening test:

1. At what age should a patient receive this test?
2. How frequently should a patient receive this test?
3. What is the appropriate followup of a positive result?
4. At what level of effectiveness, in terms of cost, will the patient accept this test? (This criterion often is set at the national level for large populations, but for the individual physician, this question has to be asked over and over again for the individual patient.)
5. Is the national or public health standard a realistic standard for my individual patient? (Beyond cost effectiveness, how well does the standard meet all the other criteria?)
6. Are test results, upon which public health recommendations are based, applicable to this individual patient and my practice?

Most of the major controversies and approaches to health screening revolve around the answers to these six questions.

RECOMMENDATIONS

A. Mammography: At what age? The American Cancer Society[1] and the National Cancer Institute[2] recommend a baseline mammography be obtained between the ages of 35 and 40, followed by annual or biennial mammograms (dependent on personal or family history) between the ages of 40 and 50, with annual mammograms after age 50. In contrast, the United States Preventive Services and Canadian Task Forces[3,4] and other authorities[5,6] recommend beginning annual mammography screening at age 50. Screening criteria of most importance in this controversy are the sensitivity, specificity, and cost effectiveness of the test.

In a number of studies, the sensitivity of mammography varies greatly with the age of the patient.[7,8] The sensitivity for detecting breast cancers in women over age 50 ranges from 80 to 87 percent, as opposed to values of 56 to 60 percent in women under age 50. The specificity of mammography ranges from 94 to 99 percent.[7,8] Although these specificity values are near ideal, false positives will occur frequently in a population with a low prevalence of the disease. Therefore, most of the abnormal mammograms in healthy, young women are likely to be false positives. The financial and emotional costs of identifying false positive results are high.

We are not alone in questioning the benefits of screening mammography in women under age 50.[3,9-11] Prospective data from the Swedish,[12] Dutch[13] or New York Health Insurance Plan[14] studies have not shown a statistically significant reduction in breast cancer mortality for women under 50 years of age.

In addition to the controversy surrounding the age of initiating mammography screening, data regarding the age to discontinue screening in the asymptomatic elderly are unavailable. Currently, the United States Preventive Services Task Force[3] recommends initiating mammography

for all women at age 50 and concluding approximately at age 75, unless pathology has been detected. For women at high risk for developing this disease, e.g. positive family history, age 35 has been recommended. One could argue that given the apparent aggressive nature of the disease in premenopausal women (poorer response to chemotherapy, more disseminated disease found earlier) that if screening is to be done at all in women less than 50 years of age, then every six months would be a more appropriate interval.

B. Papanicolaou smear: How often? Since the introduction of the Papanicolaou (Pap) smear in the 1950s, the mortality rate from cervical cancer in women has declined by 73 percent.[15] Although advances in the treatment of cervical cancer also are playing a role in this reduction, this decline illustrates the impact of the Pap smear as a screening test in the early detection of cervical cancer in the asymptomatic female. However, national guidelines regarding the frequency of Pap testing have been inconsistent, with ranges from yearly to every five years. In 1988, a consensus recommendation was issued, supported by a variety of organizations including the American Cancer Society, the American Medical Association, American College of Obstetricians and Gynecologists, and the American Academy of Family Physicians.[16] This recommendation called for the initiation of Pap testing a woman who becomes sexually active, followed by at least three normal Pap smears obtained annually. If the initial Pap smears have been normal, the interval for testing may be less frequent than yearly, upon recommendation by the patient's personal physician.

Why are there inconsistencies among the recommendations? The Pap smear, although considered an effective screening test by reviewing mortality statistics, also is a less than optimal screening test because of an associated high false negative rate ranging from 20 to 45 percent.[17-19] A vast number of factors affect the sensitivity of this test, including the difficulty in obtaining an adequate specimen, inadequate preservation and processing of the slide, and variability in reader expertise. The high rate of false negatives is quite significant, as cervical cancers may not be detected at earlier stages of disease and may progress to more advanced disease before identification.

A number of studies have shown that the risk of invasive cervical cancers correlates with the frequency of Pap smear testing, to a point. There is evidence that reducing the frequency from ten years to five years results in a significant reduction of risk.[20,21] However, further reducing the frequency to every two or three years only offers slightly greater benefits, as calculated by mathematical models from controlled studies.[21] In addition, a major study involving cervical cancer screening programs throughout Europe and Canada has shown that increasing the interval to yearly testing did not significantly reduce the risk for invasive cancer.[22] How do these inconsistencies affect the practicing physician? For the individual practitioner, obtaining yearly Pap smears on a sexually active female during the ages of 18 to 65 results in approximately 48 Pap smears for a woman's lifetime, as compared to 24 Pap smears done every other year and 16 Pap smears done every three years. From the public health point of view, these figures are multiplied by the total American female population at risk. Again, the costs of testing, in addition to the expense of followup studies of false positive results are high.

The present recommendation of the United States Preventive Services Task Force is that testing begin with the onset of sexual activity or age 18, whichever is earlier.[3] Pap testing should be repeated every one to three years, at the physician's discretion, depending on the patient's personal risk factors. In our practice, we provide women with the information that increasing the interval between Pap smears from 1 to 2 years increases their risk of dying from cervical cancer by approximately 2 per 10,000. We find that most women choose a 2-year interval given this fact.

C. Blood pressure: What is the appropriate followup for high blood pressure revealed in mass screening? The burden of suffering of hypertensive disease is great. It is estimated hypertension may exist in as many as 58 million Americans.[23] Hypertension is a known risk factor for a variety of diseases, including coronary artery disease, cerebral vascular accidents, and renal disease. The United States Preventive Services Task Force recommends that blood pressure should be measured regularly in all persons age three and older.[3] The Joint National Committee on the Detection, Evaluation, and Treatment of High Blood Pressure recommends that normotensive persons (diastolic and systolic values below 85 and 140 mm Hg, respectively) should receive blood pressure measurements at least every two years, and individuals with diastolic values ranging from 85 to 89 mm Hg should be screened annually.[23] Screening for hypertension occurs on an individual and mass basis, involving a multiplicity of sites, ranging from physician offices, work-site programs, and commercial blood pressure machines to large-scale screening programs throughout the community.

There are a number of problems with community mass screening programs for hypertension. The first problem is that patients may be erroneously labeled as hypertensive; one elevated reading does not make the diagnosis of hypertension; rather, three separate elevated readings are required. An erroneous label may affect an individual's emotional, physical,

social, and financial state. Fear of the disease may prevent an individual from seeking appropriate followup with the physician, or, conversely, patients may vigorously seek a diagnostic and treatment regimen with potential side effects. Also, an individual may be erroneously limited from obtaining full financial benefits associated with certain insurance policies, or may be excluded from social and occupational activities. On the other hand, individuals may be erroneously labeled as normotensive, if the one-time reading is inaccurate, lulling them into a false sense of security.

The major problem with mass screening programs is the frequent lack of appropriate followup for proper diagnosis and treatment of hypertensive disease. Screening is not simply the early detection of disease during a asymptomatic period, rather it is an intervention that will lead to decreased mortality and morbidity compared to that associated with the natural history of untreated disease. The most typical result of such screening is to uncover already known disease, that is, hypertension not under control or not treated at all, but known to the patient. Thus, such a screening program may be acceptable with more limited goals of remotivation and treatment of known disease. Screening on the mass scale may properly identify individuals with potential disease; however, many programs lack a good followup mechanism for intervention.

D. Guaiacs: Are hemoccult tests cost effective for the individual patient? As colon cancer is the second most common form of cancer in the United States, with an accompanying second highest mortality rate, there is a need for an appropriate, cost effective screening test for the early identification of treatable malignant and premalignant lesions. The current screening tests used are the digital examination, sigmoidoscopy, and fecal occult blood testing. The American Cancer Society recommends yearly guaiacs for all persons after age 50.[1] The Canadian Task Force recommends annual testing for high-risk persons over the age of 45.[2,4] Frame recommends testing every 2 years between the ages of 40 to 50 and yearly thereafter.[6] Because of insufficient evidence, the United States Preventive Services Task Force does not make recommendations for or against fecal occult blood testing in asymptomatic persons.[3]

Discrepancies in recommendations result from problems inherent in the characteristics of the test: sensitivity and specificity. A positive result in guaiac testing signifies the presence of blood alone; it does not screen for the presence of malignant or premalignant cells as does the Pap smear. Cancerous lesions and premalignant adenomatous polyps may produce positive results, but only if the lesion is producing enough blood (estimated at being 20 ml/day), and bleeding occurs while the test is being performed; otherwise, false negative results are obtained. Ingestion of vitamin C prior to testing also produces a false negative result as the ascorbic acid interferes with the test reagent. The test also causes concern because of the high false positive rate. Other gastrointestinal abnormalities, such as gastritis, peptic ulcer disease, hemorrhoids, and diverticulosis, may produce gastrointestinal blood loss and a false positive test result for colon malignancy. The test also must be performed properly, with the patient adhering to a proper dietary intake for approximately 48 hours prior to testing, to prevent false positive and negative tests. Common over-the-counter medications such as aspirin, NSAIDS, and iron supplements may result in false positive results, as may certain food stuffs containing peroxidases.

As a result, when dealing with an asymptomatic population, a majority of the positive results of guaiac testing do not indicate malignancy.[3] Patients with positive results currently are advised to have colonoscopy as the followup study of choice. The cost of a further workup is considerable, including patient comfort levels, both physical and emotional, and possible complication rates of ensuing medical procedures, and other costs, both in time and money.

Thus, hemoccult blood testing is not a benign screening tool, when the ramifications of a positive test are realized. Practicing physicians should be concerned when this test is available as an over-the-counter kit and as marketing ploys of managed health care plans, allowing patients to perform the test in an unsupervised fashion, without proper instructions.

E. Sigmoidoscopy: Are the standard recommendations a realistic guideline for the practicing primary care physician? As with fecal occult blood testing, the United States Preventive Services Task Force fails to recommend for or against sigmoidoscopy as an effective screening tool for colorectal cancer in asymptomatic persons, citing insufficient evidence as grounds for the conclusion.[3] However, the American Cancer Society recommends a sigmoidoscopy every 3 to 5 years beginning at age 50, after two initially normal annual screenings.[1]

The basis of screening sigmoidoscopy is the visualization of premalignant or early cancerous colorectal lesions so that treatment in the asymptomatic phase will result in decreased mortality and morbidity. If one remembers that screening only up to the sigmoid region will visualize approximately 50 to 60 percent of cancers, there exists a large possibility of false negative results. In addition, no studies are available to document that screening in an asymptomatic population will result in an improved outcome, compared to cases detected without screening. A number of studies exist that attempt to docu-

ment effectiveness, but there are many concerns relating to the design of these investigations.[3]

Casting aside the aforementioned concerns regarding false negative rates and effectiveness of the screening test, Frame asked whether the American Cancer Society recommendations are a realistic expectation for the busy primary care provider.[25] Frame estimated that a typical family physician with an active patient load of 3,000 (and a typical percentage of patients over age 50) would need to perform a total of seven sigmoidoscopies daily, five to initially screen the population and two for subsequent screening. This would leave little time for the diagnosis, management, or prevention of other diseases.

F. Cholesterol: Are the current recommendations applicable to all patient groups? Modifiable risk factors for coronary artery disease include hypertension, cigarette smoking, obesity, and high blood cholesterol. The United States Preventive Services Task Force recommends periodic measurement of total serum cholesterol with individualized treatment based on the result and accompanying coronary risk factors.[3]

The effectiveness of early detection, leading to the treatment and reduced incidence of coronary artery disease in asymptomatic individuals has been demonstrated in three well-designated studies: the WHO Cooperative Trial;[26-28] the Lipid Research Clinics Coronary Primary Prevention Trial;[29,30] and the Helsinki Heart Study.[31] The study population was asymptomatic, middle-aged men, predominantly white. The question remains whether this evidence can be applied to other populations, such as younger men, women, the elderly, or nonwhite population groups. Trials involving these population groups are lacking.

Until such time as necessary trials are completed, it may not be appropriate to recommend cholesterol dietary changes or medical interventions. This is particularly true because the consequences of such change and/or therapy are not fully understood. The recent suggestion that cholesterol-lowering diets and medicines lead to aggressive and violent behaviors is one example of such unexpected side effects.[32]

G. Routine Testing (CBC, chemistry profile, urinalysis, ECG, chest x-ray): Is baseline information useful and necessary? Often physicians routinely order a battery of tests, justifying their actions with the premise that a baseline result is valuable to help interpret changes in subsequent tests. However, when ordering tests as a screen, one must keep in mind the screening criteria discussed in Part I. Screening deals with an asymptomatic population; each individual's risk for developing the target disease is the same as for other members of the group. It is important to know the prevalence of the disease state in this asymptomatic population. Sensitivity and specificity of a test do not vary; however, the positive and negative predictive values are based on prevalence rate. In asymptomatic individuals, where the probability of a disease state is relatively low, a significant number of false positive results are generated. These false positive results require extensive followup, adding to the cost of the initial screen.

One must keep in mind the characteristics of the disease itself. Early intervention can lead to lowered mortality and morbidity as compared to detection at a later, symptomatic period. To date, there has not been documentation of improved survival with a variety of the routine tests.

Is this baseline information useful for later comparisons? When these tests are repeated in a symptomatic individual with chest pain, these tests no longer are screening tools but are part of the diagnostic evaluation. As one example, the presence of an unchanged cardiogram would not be helpful in determining whether or not a patient is having an acute coronary event. The physician's level of suspicion would govern the appropriate management decision, and not the cardiogram. In addition, many baseline tests may have been done so long ago that any changes noted in repeat testing may have taken place at any time during the interval, and not necessarily with the acute event. Finally, baseline results usually are not even available when comparisons are needed.

SUMMARY

It is hoped that practicing physicians no longer will give knee jerk reactions to the variety of national screening recommendations. Screening criteria that need to be fulfilled include characteristics of the disease, characteristics of the test, and characteristics of the population to be screened. In the day-to-day practice of medicine, six key questions regarding the application of screening recommendations to individual patients have been developed. These include the qualifying questions regarding the patient's age, frequency of testing, cost effectiveness of testing, realistic practice for the physician, appropriate setting, and applicability to the patient in question. In the future, research in the area of screening needs to focus on the demographics of a greater variety of asymptomatic population groups, the effectiveness of current recommendations and guidelines, and the development of new, effective screening tests. ■

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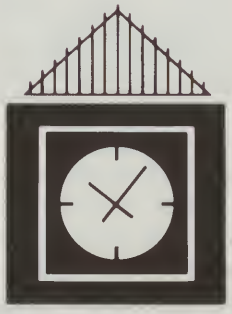
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Simulation of Breast Carcinoma

James H. Jacoby, MD

In Radiology Rounds, *the author presents a case history, mammogram, and discussion of causes of diseases simulating carcinoma of the breast. The patient is a 59-year-old female. The diagnosis is edema of the breast secondary to congestive heart failure, mimicking carcinoma.*

A 59-year-old black female presented with progressive bilateral leg edema, shortness of breath, and increased abdominal girth of two weeks' duration. Past medical history included severe peripheral vascular disease, a below-knee amputation, femoral-popliteal bypass surgery, insulin-dependent diabetes, anemia, foot ulcer and osteomyelitis, and congestive heart failure. There was no family history of breast cancer.

Physical examination revealed jugular distention and 4+ pitting edema of her extremities. Her lungs were clear. There was edema of her right breast with slight tenderness and no evidence of discrete breast mass, dimpling of the skin, axillary mass, or discharge. The left breast was normal. During the course of her hospitalization, a mammogram was performed (Figures 1A and 1B). This revealed extensive skin thickening and diffuse increased density of the right breast without discrete mass or suspicious calcification. The left breast was normal. She responded well to intravenous Lasix® and a low-sodium diet. A followup mammogram was performed ten months later (Figures 2A and 2B).

DISCUSSION

Our patient presented in congestive heart failure with unilateral diffuse skin thickening of the right breast, as well as poorly defined diffuse asymmetric increased density.

Inflammatory carcinoma can present in a very similar fashion. The hallmarks of this condition are unilateral skin thickening with subcutaneous reaction secondary to engorged lymphatics. There often is considerable diffuse mass with associated pain; neither was present in this patient.

Superior vena cava syndrome secondary to bronchogenic carcinoma has been described as a mimic of inflammatory carcinoma. Obstruction of the superior vena cava is secondary to a malignancy in 80 percent of the cases and collaterals may develop through the internal mammary, azygos, lateral thoracic, and vertebral veins. Superficial collaterals may be seen on the chest wall with or without mild to moderate bilateral skin and breast edema.



Figure 1A. Medial lateral view: Initial mammogram of the right breast showing diffuse increased density without focal evidence of abnormal mass or calcification.



Figure 1B. Craniocaudad view: Initial mammogram of the right breast showing diffuse increased density without focal evidence of abnormal mass or calcification.

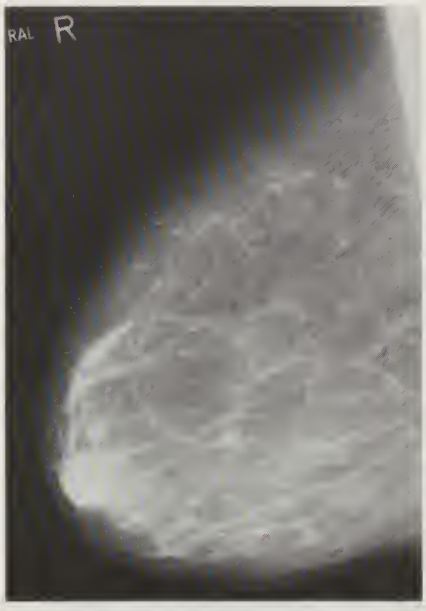


Figure 2A. Medial lateral view: Followup mammogram ten months later showing resolution of the diffuse increased density.



Figure 2B. Craniocaudad view: Followup mammogram ten months later showing resolution of the diffuse increased density.

Plasma cell mastitis is a complication of secretory disease of the breast seen in elderly women, and represents an aseptic inflammation that also can mimic carcinoma. Subareolar thickening is present without definite mass or skin fixation. Mammographically, this presents as a bilateral process with triangular-shaped subareolar areas of increased density that tend to blend with adjacent normal tissue. Either spherical, egg shaped, or elongated ductal calcifications almost always are present.

In contradistinction, acute mastitis is an infectious disease seen in younger women usually during lactation. Acute mastitis in nonlactational periods or postmenopause is distinctly unusual but may mimic inflammatory carcinoma. Fever, redness, pain, and tenderness associated with infection were absent in this case.

Fat necrosis can be seen following trauma and is accompanied by skin retraction and skin thickening, and should be considered in the differential diagnosis. Similar findings are seen following radiation therapy. Lymphatic extension from a contralateral breast cancer also should be considered but is easily excluded by history.

Edema of the breast secondary to congestive heart failure is unusual, especially unilaterally, and generally indistinguishable mammographically from other causes. The lack of associated mass and the patient's history should prompt a roentgen re-examination of the breast following correction of congestive failure.

Diagnosis: Edema of the breast secondary to congestive heart failure, mimicking carcinoma. ■

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Special Correspondence: Vision Standards

Gerald Fonda, MD

Physicians and ophthalmologists must know the vision standards for driving motor vehicles, as they are requested by patients to complete the necessary forms to obtain a restricted license. Physicians also should know why some standards are not in the best interests of their patients.

The "Vision Standards for Operating a Motor Vehicle" in New Jersey as of 1985 are a disgrace. There is no peripheral vision requirement, and a person with vision less than 20/50 can pass the vision test by looking through a telescopic spectacle. This means that an individual with 20/50 vision and a constricted field of 10 degrees can pass the vision standard. There is evidence that tunnel vision and homonymous hemianopsia are serious vision defects for driving.

There is no evidence that bioptic telescopic spectacles (BTS) are safe. The BTS consists of a carrier lens incorporating the spectacle correction when needed, with a telescope inserted through the top of the carrier lens (spectacle correction). The wearer continually looks through the carrier lens, except when he lowers his head to read a magnified sign through the telescope. An individual cannot drive looking through a telescope. Evidence proves the BTS is hazardous:

1. While reading a road sign through the telescope, a driver using the BTS is blind to traffic for a distance of 264 feet.

2. In California, for users of the BTS, the overall accident rate is 1.9 times greater and the fatal injury accident rate is 2.9 times greater than for nonusers.

3. In New York, the accident rate for users of the BTS is three times greater than for nonusers.

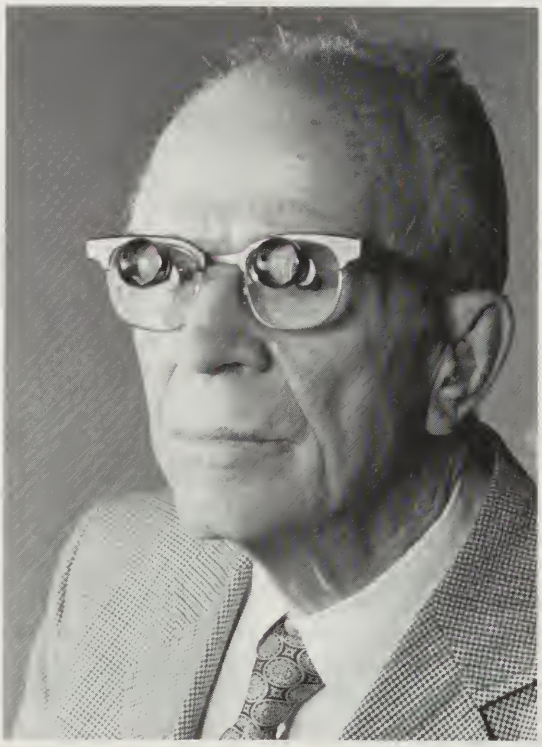
4. In Maine, the accident rate for users of the BTS is 1.8 times greater than for nonusers. Two fatalities were caused by a driver wearing the BTS.

5. In Texas, the accident rate for users of the BTS is 1.34 times greater than for nonusers.

6. In Virginia, the accident rate for users of the BTS is 3.5 times greater than for nonusers.

7. In Iowa, one man was involved in eight of nine accidents while wearing the BTS.

To compel a person to purchase the BTS to pass the vision test is exploitation of the handicapped. The cost of the BTS for a physician ranges from $400 to $1,300; the patient pays a minimum of $800 to $2,600. The BTS is good for the greedy ophthalmologist or optometrist, and the BTS is a hazard for the handicapped using it.



NJ ADMINISTRATIVE CODE 13:21-8.10 VISUAL ACUITY TEST STANDARDS

(a) Vision will be considered as passing when a minimum of 20/50 is attained in each eye, with or without corrective lenses. This rating will be determined as measured by the Snellen chart.

(b) When the vision in either eye is less than 20/50 and cannot be improved by means of corrective lenses, a certificate adequately explaining the deficiency and signed by a New Jersey registered physician, ophthalmologist, or optometrist, must be presented.

(c) When the vision in either eye is less than 20/50 and corrective lenses will improve the vision, then corrective lenses will be required to be worn while driving; except where corrective lenses show an improvement, but wearing lenses would be detrimental to the applicant's visual well being, a statement to this effect, signed by a New Jersey registered physician, ophthalmologist, or optometrist, must be presented.

(d) When there is no vision in one eye, the good eye must meet the minimum standard of 20/50 with or without corrective lenses.

(e) In the event any special device or equipment is used or needed to meet the minimum requirements outlined in this section, the matter may be referred to safety standards/driver testing for final determination.

RECOMMENDATIONS

I. Unrestricted license. Visual acuity of 20/50 in one eye with or without corrective lenses and an uninterrupted horizontal field of 140 degrees. If a lens correction is needed to improve vision to 20/50 or better, the lens correction must be worn while driving.

II. Restricted and conditional license. Visual acuity ranging from less than 20/50 to 20/200 in one eye with or without corrective lenses and an uninterrupted horizontal visual field not less than 120 degrees. If the lens correction improves vision, it must be worn while driving. Conditions for a limited license need to be flexible, taking into consideration the person's driving experience, purpose of driving, range of vision, and limitations other than that of vision. An experienced driver with no accidents or violations for many years and vision of 20/70 may need no restrictions, but a driver with 20/160 should be restricted to daylight driving not over 45 miles per hour.

OBTAINING A RESTRICTED LICENSE

1. The patient should take the form from Department of Motor Vehicles (DMV) to an ophthalmologist or optometrist to be completed.

2. The form is completed by an ophthalmologist or optometrist with recommendations concerning vision and referred back to DMV.

3. A DMV official will decide whether a road test is indicated and proceed accordingly. A DMV official will make the final decision for granting the restricted license after evaluating the driving skills and knowledge of driving rules and regulations. ■

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Dr. Fonda is affiliated with Saint Barnabas Low Vision Center, West Orange. Requests for reprints may be addressed to Dr. Fonda, Saint Barnabas Low Vision Center, 101 Old Short Hills Road, Suite 102B, West Orange, NJ 07052.

PRO Changes Under the Fourth Scope of Work for Medicare

David I. Kingsley, MD

The Fourth Scope of Work for the Medicare Program will become effective on December 1, 1991. This program will change the methodology utilized by peer review organizations throughout the country in performing federally mandated review of the medical care provided to Medicare patients.

The Health Care Financing Administration (HCFA) announced its intention to launch a major new initiative under the Fourth Scope of Work for the Medicare Program (1991 to 1994) that significantly will change the methodology utilized by peer review organizations (PROs) throughout the country in performing federally mandated review of the medical care provided to Medicare patients.

The new initiative, the Uniform Clinical Data Set (UCDS), was developed by the Health Standards and Quality Bureau (HSQB). UCDS is a data collection and case finding system that will result in a decrease in the number of reviews performed by PROs nationwide. However, those records selected will be subject to a much more intensified review. HCFA's goal is to systematically collect information on a national level regarding outcomes and geographic practice variations that will be analyzed to determine effective treatment modalities. PROs then will be responsible for reporting these findings to the physician and provider community in their states. The end result is that caregivers will be given pertinent information to enable them to improve their practice patterns and, in turn, will further enhance the quality of care provided.

In New Jersey, the Fourth Scope of Work for the Medicare Program is expected to go into effect on December 1, 1991. HCFA is allowing PROs six months from the start of their contract to make the necessary preparations for implementing UCDS. Therefore, this new system should be implemented in New Jersey on June 1, 1992.

UCDS, a software program, will be used by the nurse utilization review coordinators who initially screen medical records selected for PRO review. UCDS will allow utilization review coordinators to collect a standard set of data about each hospitalization, and will subject that data to an encyclopedic system. Although UCDS includes 1,600 elements, the number of data items collected for each case varies depending on the patient's medical condition. On average, 250 to 300 elements will be collected per case. The data elements to be collected include: administrative information, e.g. patient identifying information, diagnosis and procedure codes, discharge disposition; sociodemographic data; admission status; admission medication history; history of permanent anatomic changes; history and physical; laboratory findings; selected diagnostic tests; endoscopic procedures; operative episodes; noninvasive treatment interventions; hospital course, e.g. special care unit day; patient discharge status; and discharge planning.

UCDS will determine whether or not a particular record passes the initial screening or needs to be referred to a physician reviewer for final determination. If UCDS determines that physician review is necessary, it will provide to the physician reviewer a case summary that reflects the specific areas to be addressed. HCFA's intent is to ensure that cases are selected for physician review in each state by the same standards, thus eliminating differences in PRO review results attributable to individual nurse judgment. Further, the data being collected are going to be matched to other Medicare data files to enable longitudinal analyses to be performed. This is intended to yield significant information about the effectiveness of different medical interventions, and may lead the PRO program away from the necessity of performing case-by-case review, and toward a broader based epidemiological analysis of health care by the Medicare program.

The big change under the Fourth Scope of Work for the

HCFA: Health Care Financing Administration
HSQB: Health Standards and Quality Bureau
PRO: Peer review organization
QIP: Quality Intervention Program
UCDS: Uniform Clinical Data Set

Medicare Program will be the implementation of UCDS. The Quality Intervention Program (QIP), introduced in the Third Scope of Work (1988 to 1991), will remain in effect under the next Scope. The QIP requires PROs nationwide to assign severity levels and weighted scores to confirmed quality problems. HCFA-mandated interventions are taken based upon the weighted score attained by a practitioner or provider in a quarter.

In March 1991, The PRO of New Jersey, Inc. released its first *Report of Review Activities for the Medicare Program* that included data outlining the results of the QIP and other review activities undertaken by the PRO during the first two years (December 1988 to November 1989 and December 1989 to November 1990) of the present Medicare contract. This report, sent to 16,000 physicians and Medicare-certified providers throughout the state, showed that during the first year of the 1988 to 1991 Medicare contract, The PRO of New Jersey, Inc. identified confirmed quality problems in 0.43 percent of the cases reviewed. During the second year of the contract, this increased to 1.47 percent. Overall, when compared to findings by PROs throughout the country, the percentage of confirmed quality problems in New Jersey is less than the national average.

The government's focus has changed significantly since the First Scope of Work for the Medicare Program was initiated in 1984. At that time, the focal point was on utilization of services in an attempt to contain escalating health care costs. Although utilization of services continues to remain an important part of the federal program, the emphasis has increasingly shifted to quality of care. With the onset of the Fourth Scope of Work, the PRO's role will move to another plane—with the primary emphasis on performing practice pattern analysis with the end result of educating physicians regarding possibly more effective modes of treatment. It also is important to note that the Preadmission/Preprocedure Review Program probably will be eliminated or targeted to areas where impact has been demonstrated. Preprocedure review for the use of assistant surgeons during cataract surgery and intraocular lens implant is expected to remain in effect. Review of transfers and readmissions is expected to be reduced; it will be required only as it applies to cases selected as part of the random sample.

We are doubtless going to be seeing more changes in the federal review process over the years. The direction in which it seems to be going at the present time is a positive and potentially more realistic one. ■

Dr. Kingsley is president of The Peer Review Organization of New Jersey, Inc. Address requests to Dr. Kingsley, The PRO of New Jersey, Inc., Brier Hill Court, Building J, East Brunswick, NJ 08816.

DOCTORS' NOTEBOOK

TRUSTEES' MINUTES

A regular meeting of the Board of Trustees was held on April 27, 1991, at the Trump Taj Mahal Casino/Resort, Atlantic City. Detailed minutes are on file with the secretary of your county society. A summary of significant actions follows:

President's Report ... Announced that Dr. Warren Werbitt, Camden County, received the Professional Service Award.

Exec. Director's Report ...

(1) **Medicare** ... Noted the following items dealing with Medicare: HCFA's announcement that 13 Part B carriers will test whether disclosure of screening parameters affects physician billing practices; seven Physician Payment Reform Commission recommendations; OBRA 1990 physician payment cuts; report with the Medicare cash disbursements for fiscal years 1986 through 1990; notification by Pennsylvania Blue Shield of the health manpower shortage area incentives; and payment for assistants at surgery for the following hernia codes: 49500, 49505, 49510, 49515, 49520, 49525, 49950, 49555, 49570, 49575, 49580, 49581.

(2) **Litigation** ... Noted the following: a suit has been filed regarding physician assistants; decision of the Supreme Court regarding medical malpractice surcharge will be forthcoming; the state has filed a motion to move the entire no-fault case from the Tax Court to the Appellate Division; MSNJ will make a request to file an amicus brief before the State Board of Medical Examiners in the case dealing with the liability of a physician for negligence performed by a subordinate in a situation when the physician having responsibility for the supervision of the individual had no obligation to be personally present; development of a position on the ruling of the proposed business practice rule; one-year moratorium on the loss of an AMA delegate due to reduced membership; and creation of the position of vice-president of the NJ State Medical Underwriters.

Council on Legislation ... Approved all the positions recommended by the Council on Legislation concerning current state legislation.

Committee on Medical Aspects of Sports ... Approved the following recommendation:

That the Medical Society of New Jersey urge the New Jersey School Board Association to recommend that the school systems vigorously pursue policies that would give some rudimentary insurance coverage to all students, with a secondary policy available at a reasonable cost to parents who wish to have that coverage.

Unfinished Business ... Noted that "Doctors' Day at the Legislature" was effective and MSNJ will continue to prepare for future efforts of this type with organized communications and activities; and Dr. Carnes distributed information to assist volunteers campaigning for hospital medical staff contributions to MedAC.

New Business ... Referred the issue regarding the physician courtesy referral program, based on Dr. Samson's concept, to the Council on Medical Services for consideration.

MINUTES

A reorganization meeting of the Board of Trustees was held on May 1, 1991, at the Trump Taj Mahal Casino/Resort, Atlantic City. Detailed minutes are on file with the secretary of your county society. A summary of significant actions follows:

Reorganization ... Welcomed the newly elected officers: Dr. William E. Ryan, president-elect; Dr. Joseph N. Micale, first vice-president; Dr. Fred M. Palace, second vice-president; and welcomed the following trustees: Dr. Irving P. Ratner; Dr. A. Ralph Kristeller; Mr. Devang Shah; and Dr. Stevan Adler.

President's Report ... Reported on a private conference with Governor Florio to continue a dialogue between government and physicians regarding health care reform.

Referrals from the 1991 House of Delegates ...

(1) **Substitute Resolution #14 (HIV Testing for Hospital Patients)** ... Referred the following to the Task Force on AIDS for consideration and development of a comprehensive report to the Board:

Resolved, that MSNJ support universal HIV testing to be performed on all hospitalized patients; and be it further

Resolved, that MSNJ support periodic universal HIV testing of all health care personnel, including physicians; and be it further

Resolved, that any individual who tests positive on both the ELISA and Western blot tests be so informed and receive counseling; and be it further

Resolved, that any HIV test results be treated with the utmost confidentiality.

(2) **Substitute Resolution #5 (Uncompensated Care)** ... Noted that the following was referred to the Board for consideration:

Resolved, that MSNJ continue exploration of mechanism for compensation of physicians for the care of uninsured patients.

(3) Substitute Resolution #7 (Physician Uncompensated Care Fund) . . . Noted that the following was referred to the Board for consideration:

Resolved, that MSNJ endorse "Health Access New Jersey" and take whatever steps are necessary to implement that policy; and be it further

Resolved, that MSNJ actively pursue the introduction of legislation to provide remuneration for physician services currently rendered pro bono in hospitals throughout the state.

(4) Resolution #2 (Reinstatement of Members) . . . Referred the following to the Ad Hoc Committee on Membership for development of a comprehensive policy to be reviewed and approved by the Board:

Resolved, that if a hiatus in dues payment to MSNJ of greater than 12 months from June 1 exists, there shall not be a delinquency assessment payment to MSNJ.

(5) Resolution #10 (Bicycle Helmets and Safety) . . . Referred the following to the Committee on Medical Aspects of Sports for review and comment:

Resolved, that MSNJ actively support bicycle helmet use and encourage physicians to educate the public about the importance of bicycle helmet use; and be it further

Resolved, that MSNJ encourage the manufacture, distribution, and utilization of safe, reasonably priced bicycle helmets; and be it further

Resolved, that MSNJ encourage the availability of helmets at the point of bicycle purchase; and be it further

Resolved, that MSNJ support proposed legislation requiring bicycle safety helmets.

(6) Resolution #12 (Sale of Tobacco Products by Pharmacies) . . . Agreed to send a letter to the president of the New Jersey Pharmaceutical Association concerning the following:

Resolved, that MSNJ support the New Jersey Pharmaceutical Association and related organizations in their efforts to promulgate policies and procedures encouraging retail pharmacies throughout the state to ban the sale of tobacco products from their premises.

(7) Resolution #13 (No Guest Speaker at Last Day of MSNJ House of Delegates) . . . Will refer the following to the speaker and vice-president of the House and to the Committee on Annual Meeting for consideration in the preparation of an agenda for future MSNJ meetings:

Resolved, that guest speakers, out of state or otherwise, routinely be scheduled to address the House of Delegates at the first and second sessions, leaving the final session for consideration of reference committee reports.

(8) Resolution #1 (Medicare Notification of Payment) . . . Will refer the following to the AMA Delegation for preparation of a suitable resolution to be introduced to the AMA House of Delegates:

Resolved, that MSNJ request that the Medicare carrier acknowledge receipt and disposition of nonassigned claims; and be it further

Resolved, that this resolution be forwarded to the AMA with the request that the Health Care Financing Administration (HCFA) mandate Part B carriers to furnish other participating and nonparticipating physicians with an explanation of Medicare benefits (EOMB) on all claims, whether assigned or nonassigned.

(9) Resolution #11 (Physician Advisory Committees to Insurance Companies) . . . Will direct a communication to county medical societies and presidents of hospital medical staffs for the following:

Resolved, that the House of Delegates urge each county medical society, along with the hospital staffs within that county, to form a physician advisory committee to consult with insurance companies on issues regarding the medical needs of the community; and be it further

Resolved, that MSNJ, and representatives of county advisory committees, form a state physician advisory committee to consult with the New Jersey State Department of Health and the New Jersey State Department of Insurance on issues regarding the medical needs of the state.

(10) Resolution #16 (Fee Negotiations and Insurance Complaints) . . . Adopted the following; noted that the commissioner agreed that if a physician accepts assignment on any commercial insurance policy, or PIP policy, he may be a direct party complainant, with or without the patient's signature and a letter will be sent to the Health Insurance Association of America, and to the Associations to which the worker's compensation insurance carriers and casualty carriers belong, urging their members be requested to comply with the resolution:

Resolved, that MSNJ urge the commissioner of insurance to allow physicians the right to originate complaints directly to the New Jersey State Department of Insurance; and be it further

Resolved, that MSNJ notify the insurance industry that fee disputes should be considered for arbitration and the uncontested amount paid promptly, with the negotiating conference quickly scheduled and the final allowed balance paid within 15 days.

(11) Resolution #17 (Reimbursement of Nonassigned Claims) . . . Referred the following to the Council on Legislation for implementation:

Resolved, that MSNJ actively sponsor and seek enactment of legislation or regulations that would require all insurance companies selling health insurance policies in New Jersey to honor the patient's assignment of medical expense benefits to the physician whenever duly executed.

(12) Resolution #18 (Home Health Care Services) . . . Will refer the following to the AMA Delegation for preparation of an appropriate resolution to be introduced to the AMA House of Delegates:

Resolved, that MSNJ, through its AMA Delegation, encourage the AMA, as a priority item, to vigorously petition Congress and the Health Care Financing Administration to authorize adequate reimbursement for home health care case management by physicians.

(13) Substitute Resolution #3 (Funding for University of

Medicine and Dentistry of New Jersey) ... Will send a letter to the governor and the appropriations committees of the Senate and Assembly concerning the following:

Resolved, that MSNJ communicate with the governor and Legislature that state funds for the education of medical students at UMDNJ not be cut out of proportion to the budgetary restraints imposed on other state agencies or institutions.

(14) Resolution #9 (Check Seniors' Medications) ... Referred the following to the Council on Public Relations for development of an appropriate program:

Resolved, that MSNJ adopt a public relations program advising senior citizens to take all their accumulated medications, both prescription and over the counter, to their physicians to review appropriateness, dating, dosage, drug interactions, and side effects; and be it further

Resolved, that there be published advertisements and articles in *NEW JERSEY MEDICINE* to familiarize physicians with this program and the existing Auxiliary and MSNJ MediFile Program; and be it further

Resolved, that county medical societies be encouraged to adopt a similar information program.

NJHA Council on Finance Draft Position Paper ... Will express appreciation for the efforts in developing a position on the uncompensated care issue; response will note MSNJ's recognition of the problem and the plan of action taken. Also, referred to the Council on Medical Services to report on existing programs to assist medical staffs in developing such a mechanism in their respective hospitals. □

UMDNJ NOTES

Commencement. The University of Medicine and Dentistry of New Jersey (UMDNJ) awarded professional degrees and certificates to 789 students at its 18th annual commencent ceremony. UMDNJ also presented the University's Distinguished Alumna Award to the New Jersey Commissioner of Health, Dr. Frances J. Dunston, a 1978 graduate of UMDNJ-Robert Wood Johnson Medical School, and an honorary degree to Dr. Felix Milgrom, a pioneering biomedical scientist.

Tuition increase held to 5.7 percent. Despite a $2.5 million cut in its state appropriation, UMDNJ will raise tuition rates only 5.7 percent, the current national inflation rate. The UMDNJ Board of Trustees, recognizing that UMDNJ tuition rates for medical and dental education are relatively high already, voted to raise the annual tuition for medical and dental students to $11,053 for New Jersey residents and $14,505 for nonresidents for the academic year beginning September 1991. The line on tuition is being held despite a 16 percent budget cutback in UMDNJ's state appropriation, representing a loss of $25.2 million. The idea is to minimize the burden on students, who already pay high tuition. The University has made some extremely difficult decisions in dealing with a budget cut of this magnitude. Under the circumstances, the tuition increase is moderate and allows UMDNJ to continue to offer good quality and good value in its programs.

Program targets homeless drug abusers. Homeless men who also are alcohol and drug abusers are getting help in finding homes and jobs in an innovative research program initiated by UMDNJ-New Jersey Medical School and the city of Newark. The joint study is testing new solutions to the growing urban problem of addicted homeless men. The thrust of the plan is to bring social services, including specialized prevocational training, to the individual. The study, called "Homelessness, Substance Abuse: An Investigation of Two Interventions," is being operated by the medical school, Newark's Division of Public Welfare, and the Archbishop Boland Rehabilitation and Training Center of Newark. The three-year study is supported by a $2.8 million grant from the National Institute on Alcohol Abuse and Alcoholism of the National Institutes of Health.

Recycling effort. By recycling more than 60 percent of the solid waste produced at its Newark campus, UMDNJ has achieved a state environmental goal nearly four years ahead of schedule. Based on recommendations by the Governor's Emergency Solid Waste Assessment Task Force, the New Jersey State Department of Environmental Protection set goals for the state's colleges and universities of 25 percent solid waste recycling by 1991 and 60 percent recycling by 1995. In January, February, and March 1991, the Newark campus recycled an average 64 percent of its solid waste. The University-wide average is 56 percent. The effort is saving UMDNJ more than $100,000 a year in disposal costs.

Simplified procedure removes spider veins. A simple procedure to remove unsightly and often uncomfortable spider veins is available at UMDNJ-Robert Wood Johnson Medical School in New Brunswick. Spider veins are small dilated blood vessels, or capillaries, visible on the surface of the skin as either red or blue fine lines. They usually appear on the lower leg.

Drs. Lynn Bickley and Susan Primmer, dermatologists, treat the condition by injecting a salt solution into the vessel. The solution irritates the capillary lining, causing the vessel to form scar tissue. Often, several injections are required before the vessel is unable to carry blood and becomes invisible. Side effects, usually mild and short-lived, may include brownish freckling or blistering at the site of the injection or some swelling.

Toyota award to environmental program. The Toyota USA Foundation has awarded a $53,300

grant to the Foundation of UMDNJ. The grant will assist the Environmental and Occupational Health Information Program (EOHIP) at UMDNJ-Robert Wood Johnson Medical School, Piscataway. The grant will be used to support "Healthy Environment-Healthy Me," an interdisciplinary environmental education program for kindergarten through sixth-grade students. The program, that targets a different topic for each grade level, provides youth with an understanding of the environment and their impact on it. ☐ Stanley S. Bergen, Jr, MD

MSNJ AUXILIARY

Mrs. Jean Taboada, MSNJ Auxiliary president, presented the following speech upon her inauguration:

I was introduced to the Medical Society Auxiliary while I was in high school when the Monmouth County Medical Society Auxiliary awarded me a nursing scholarship. Today, I am proud to accept the leadership of the Medical Society of New Jersey Auxiliary and to continue its commitment to good health.

Because of advances in medicine and changes in the workplace, this goal has become more complex, but the Auxiliary profile also has changed. By pooling the increased expertise of our members, we can and we will meet this challenge.

We have a solid foundation of programs on which to build. Donations to the American Medical Association–Education Research Foundation (amounting to over $2 million last year) go directly to medical schools to ensure quality medical education. Other health care providers receive funds through local Auxiliary scholarship programs. We are active in the legislative process and encourage responsible health legislation. We reach out to the community with health education programs that range from the use of infant care seats, to teenage health topics, and geriatric programs.

These programs should continue to be our mainstays, but we must incorporate healthy lifestyles and wellness into our educational programs. We must instill in our youth that health is everyone's personal responsibility. By choosing a healthy lifestyle today they can look to a happy, productive, and more secure future.

We can accomplish these goals if we utilize the diverse expertise of our membership, network with their contacts in the workplace, and work in coalition with other health-related groups. The Auxiliary needs every physician's spouse to join our ranks. Together we can make a difference. ☐



Mrs. Jean Taboada

PLACEMENT FILE

The following physicians have written to the executive offices of MSNJ seeking information on opportunities for practice in New Jersey. If you are interested in information concerning these physicians, we suggest you make inquiries directly to them.

Family Medicine

Vicente F. Franco, MD, 9362 Bay Colony Dr., Apt. 1S, Des Plaines, IL 60016. Universidad Central del Este 1982. Board eligible. Available.

Gastroenterology

Howard Merzel, MD, 91 Wilshire Rd., Rochester, NY 14618. Medical College of Wisconsin 1984. Board certified. Group or partnership. Available.

Internal Medicine

Anand M. Gupta, MD, 338 McDowell Dr., East Brunswick, NJ 08816. India 1986. Board eligible. Solo, partnership, group. Available.

Sheryl S. Hertel, MD, 6205 Brogan Pl., St. Louis, MO 63128. St. Louis 1986. Also, pediatrics. Board certified; board eligible (PED). Group. Available August 1991.

M. Stekelman, MD, P.O. Box 900, Hightstown, NJ 08520. BSAS (Argentina) 1959. Also, gastroenterology. Board eligible. Outpatient or ambulatory facility. Available.

Obstetrics/Gynecology

Dennis Tumbokonm, MD, P.O. Box 476, Kimball, WV 24853. University of the East. Board eligible. Solo. Available.

Pediatrics

Sheryl S. Hertel, MD, 6205 Brogan Pl., St. Louis, MO 63128. St. Louis 1986. Also, internal medicine. Board eligible. Board certified (IM). Group. Available August 1991.

Radiation Oncology

Carol L. Kornmehl, MD, 133 Wyncrest Rd., Marlboro, NJ 07746. SUNY-Downstate 1984. Board certified. Group, partnership, solo. Available.

Surgery

Nichlas J. Dudas, MD, 915 Princeton Ave., Philadelphia, PA 19111. UMDNJ 1986. Board eligible. Group or partnership.

Urology

S. Misra, MD, 8161 Gatewood Dr., Clay, NY 13041. SCB-Orissa (India) 1977. Board eligible. Group or partnership. Available.

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A symposium designed for the general medical practitioner, orthopaedist, neurologist, chiropractor, physical therapist and rehabilitation nurse specialist. This course is intended to assist participants with staying abreast of the most recent, scientifically supported, conservative treatment approaches and review of current diagnostic procedures available for low back pain.

Accreditation:

UMDNJ	14 Credit Hours, Category I
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NJAPTA	1.3 Continuing Education Units
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This program is offered in cooperation with: The University of Medicine and Dentistry of New Jersey, Center for Continuing Education in the Health Professions.

Information: Maria De Francesco, Conference and Exhibit Director, East Coast Continuing Education Center, Inc., 1585 Morris Avenue, Union, New Jersey 07083 (908) 686-0836, Fax: (908) 686-9250.

MSNJ WRITING COMPETITION

for INTERNS/RESIDENTS/ FELLOWS/STUDENTS

A **$500 AWARD** will be presented annually by the Medical Society of New Jersey to the intern, resident, fellow, or 4th-year medical student who submits the best paper on a clinical subject for the Society's 1991 Competition.

Entries should be "sponsored" by a faculty member, and all papers submitted should be of sufficient quality to be considered for publication in NEW JERSEY MEDICINE.

See page 515

CONTINUING EDUCATION

MEDICINE

August

6 **Caesarean Section Rates**
12:15-1:30 P.M.—John Fitch Plaza, Trenton
(AMNJ)

21 **Pulmonary Grand Rounds**
11:30 A.M.-12:30 P.M.—Newcomb Medical Center, Vineland
(AMNJ)

29 **Lyme Disease**
12 Noon-1 P.M.—Carrier Foundation, Belle Mead
(Carrier Foundation)

September

9 **New Developments in Emergency Medical Care**
7-8 P.M.—Wallkill Valley General Hospital, Sussex
(AMNJ)

21 **Diagnosis and Surgical Management of Lacrimal Disorders: Ophthalmology Medical Conference**
All day—Englewood Hospital, Englewood
(Englewood Hospital)

PSYCHIATRY

August

1 **Postpsychotic Depression**
12 Noon-1 P.M.—Carrier Foundation, Belle Mead
(Carrier Foundation)

8 **Transcultural Treatment in Issues in Psychiatry**
12 Noon-1 P.M.—Carrier Foundation, Belle Mead
(Carrier Foundation)

15 **Music Therapy with Psychiatric Patients**
12 Noon-1 P.M.—Carrier Foundation, Belle Mead
(Carrier Foundation)

29 **Lyme Disease**
12 Noon-1 P.M.—Carrier Foundation, Belle Mead
(Carrier Foundation)

September

5 **Multiple Sclerosis: Neurological and Psychiatric Manifestations**
12 Noon-1 P.M.—Carrier Foundation, Belle Mead
(Carrier Foundation)

12 **MRI and PET Scanning in the Evaluation of Alzheimer's Disease**
12 Noon-1 P.M.—Carrier Foundation, Belle Mead
(Carrier Foundation)

19 **HIV in a Psychiatric Hospital**
12 Noon-1 P.M.—Carrier Foundation, Belle Mead
(Carrier Foundation)

25 **Dual Diagnosis: The Double Burden of Addiction and Psychiatric Illness**
All day—Carrier Foundation, Belle Mead
(Carrier Foundation)

IN MEMORIAM

ALICE L. CLARK

The first woman member elected to the Hunterdon County Medical Society, in 1936, Alice Lapham Clark, MD, passed away in Florida, on March 23, 1991, at the age of 87. Dr. Clark was born in White Cloud, Michigan, on September 9, 1903, earned her medical degree from the University of Buffalo School of Medicine in 1933, and served an internship at Buffalo City Hospital. Dr. Clark received her New York and New Jersey medical licenses in 1933 and 1934, respectively. A family practitioner, she practiced in Lambertville, Trenton, and Toms River. Dr. Clark was affiliated with Point Pleasant Hospital and Mercer Hospital, Trenton. She was a member of the American Medical Association, of our Ocean, Hunterdon, and Mercer County components, and of the American Medical Women's Association. Dr. Clark was involved in various civic activities, including the First Aid Society. She retired to Florida.

ROBERT A. COOPER

A member of our Camden County component, surgeon Robert Arthur Cooper, MD, died February 1991. Born in Pennsauken on December 26, 1908, Dr. Cooper attended Temple University School of Medicine, Philadelphia, earning his medical degree in 1940. He maintained a practice in Camden and resided in Pennsauken and Cherry Hill. Dr. Cooper was affiliated with Cooper Hospital/University Medical Center and the former Zurbrugg Memorial Hospital, Riverside. Dr. Cooper was a diplomate of the American College of Surgery, a fellow of the American College of Surgeons, and a member of the American Medical Association. A World War II veteran, Dr. Cooper served in the medical corps.

ANTHONY J. DELARIO

At the grand age of 90, Anthony James Delario, MD, passed away on February 6, 1991. Dr. Delario was born in Elmira, New York, on March 20, 1900. He was awarded his medical degree from Cornell University Medical College, New York, in 1927, and completed an internship at New York Hospital, and residencies at Cornell University and at Memorial Hospital. A radiologist, Dr. Delario maintained a practice in Paterson and was head of the radiation therapy department at St. Joseph Hospital and Medical Center, Paterson, and a member of the St. Joseph Hospital Tumor Clinic. Dr. Delario was a diplomate of the American Board of Radiology; a member of the American Medical Association and of our Passaic County component, serving on the tumor committee and as chairman of the medical defense committee; and author of two books and numerous articles on the diagnosis and treatment of disease by x-ray and radium.

MORRIS DIRDACK

General practitioner Morris Dirdack, MD, passed away on October 7, 1990. Dr. Dirdack was born in New York City on November 6, 1914, and earned his medical degree from Anderson

College of Medicine, Scotland, in 1941. He received his New Jersey medical license in 1945. Dr. Dirdack maintained a practice in Morristown and was affiliated with All Souls Hospital, Morristown Memorial Hospital, and Shonghum Mountain Sanatorium, all in Morristown. Dr. Dirdack was a member of the American Medical Association and of our Morris County component, and a fellow of the American College of Chest Physicians. Dr. Dirdack relocated to Miami Beach, Florida.

JOHN F. HENNESSY

On April 2, 1991, John Francis Hennessy, MD, died at the age of 70. Dr. Hennessy was born in Bayonne, on August 28, 1920, and was awarded his medical degree from the University of Maryland School of Medicine, Baltimore, in 1945. Dr. Hennessy completed an internship at St. Francis Hospital, Jersey City, and residencies at Paterson General Hospital and Holy Name Hospital, Teaneck. He received his New Jersey medical license in 1948. An obstetrician and gynecologist, Dr. Hennessy practiced in Paterson and was on staff at Paterson General Hospital and at The Valley Hospital, Ridgewood. Dr. Hennessy served as a captain in the United States Army Medical Corps from 1946 to 1948; was a member of our Passaic County component and of the American Medical Association; and a fellow of the American College of Obstetricians and Gynecologists and of the American Society of Abdominal Surgeons. Dr. Hennessy retired to Vermont.

RHYS JONES

At the grand age of 96, Rhys Jones, MD, passed away on January 2, 1990. Born in Pennsylvania on December 21, 1894, Dr. Jones was awarded his medical degree from the University of Pennsylvania School of Medicine, Philadelphia, in 1921. An obstetrician and gynecologist, Dr. Jones maintained a private practice in Montclair and was affiliated with the former Essex County Sanatorium, Verona; and The Mountainside Hospital, and Community Memorial Hospital, both in Montclair. Dr. Jones resided in Montclair and Chevy Chase, Maryland. Dr. Jones was a member of our Essex County component and of the American Medical Association.

RAYMOND E. MILLER

A member of our Mercer County component, Raymond Everett Miller, MD, died December 25, 1990. Born December 3, 1909, in Trenton, Dr. Miller received his medical degree from Yale University School of Medicine, in 1933, and his New Jersey medical license in 1946. Dr. Miller completed his internship and residency at New York Hospital, New York City. After serving in the Medical Corps stationed in the Pacific during World War II, Dr. Miller was a professor at Cornell University Medical College, New York. Returning to Trenton, Dr. Miller practiced there for over 40 years. Dr. Miller was an internist specializing in pulmonary disease and was affiliated with Helene Fuld Medical Center, Trenton, William McKinley Memorial Hospital, Trenton, and Hamilton Hospital. Dr. Miller helped to establish Helene Fuld Medical Center, serving on its board of trustees. Dr. Miller was a professor at Hahnemann University, Philadelphia, and at Rutgers University. Dr. Miller was a member of the AMA; a fellow of the American College of Cardiology and of the American College of Chest Physicians; and a diplomate of the American Board of Pulmonary Disease.

HERBERT NEUWALDER

A member of our Bergen County component, Herbert Neuwalder, MD, died on February 20, 1991, at the age of 90. He retired in 1980. During World War II, Dr. Neuwalder practiced in Vienna and was one of the last Jewish doctors to close his practice. Born in 1900 in Barmen, Germany, Dr. Neuwalder was a 1925 graduate of the University of Vienna, Austria. He completed an internship in 1926 at Krankenhaus de Wiener Kaufmannschaft, Vienna, Austria. From 1932 to 1939, he maintained a private practice in Vienna. In 1939, Dr. Neuwalder escaped to Italy but was captured and held at the Ferramanti Concentration Camp until 1943. After liberation, he worked for the American Joint Distribution Committee, in Italy, until 1948. In 1949, Dr. Neuwalder relocated to the United States; he was affiliated with the Hebrew Home and Hospital for the Aged, Brooklyn, Bikur Cholim Convalescent Home, Mount Vernon, New York, Williamsburgh General Hospital, Brooklyn; and maintained a private practice from 1960 to 1970. After receiving his New Jersey medical license in 1971, Dr. Neuwalder opened a family practice in Dumont and Harrington Park, and was a senior attending at Englewood Hospital. Dr. Neuwalder was a member of the AMA.

WALTER NUDELMAN

Word has been received of the death of Walter Nudelman, MD, of Harding Township, on March 12, 1991. Dr. Nudelman was born in Somerville on April 19, 1924. He graduated with a medical degree from the New York University School of Medicine, in 1947, and received his New Jersey medical license the following year. Dr. Nudelman completed an internship at Newark Beth Israel Medical Center and residencies at Goldwater Memorial Hospital, New York, and Newark Beth Israel Medical Center. Dr. Nudelman maintained a private practice in internal medicine in Essex and Union counties; was affiliated with Newark City Hospital, Newark Beth Israel Medical Center, and Saint Barnabas Medical Center, Livingston; a professor at UMDNJ; a diplomate of the American Board of Internal Medicine; a fellow of the American College of Chest Physicians; and a member of our Union and Essex County components, of the Academy of Medicine of New Jersey, and of the American, New Jersey, and Essex County Heart Associations. Dr. Nudelman received the Daughters of the American Revolution Prize for History, the Bausch and Lomb Science Prize, and the Rensselaer Polytechnic Institute Mathematics Prize. Dr. Nudelman served in the United States Navy during World War II and as a physician in the United States Air Force during the Korean conflict. Dr. Nudelman resided in South Orange before moving to Harding Township 12 years ago.

CARMINE L. PECORA

Born June 29, 1911, in Belleville, Carmine Louis Pecora, MD, passed away January 8, 1991, in Florida. After earning his medical degree from Hahnemann University, Philadelphia, in 1937, Dr. Pecora completed an internship at Newark Memorial Hospital and a residency at Newark City Hospital. Dr. Pecora also studied cardiology at Einstein Medical College, Philadelphia, and electrocardiology at Michael Reese Hospital, Chicago. Dr. Pecora received his New Jersey medical license in 1938. A general practitioner, Dr. Pecora maintained a practice in Beachwood and Toms

River. Dr. Pecora was a pioneer in the effort to have Community Memorial Hospital, Toms River, built in 1961, serving as a charter member, past president of the medical-dental staff, and chairman of the Department of Medicine and of the Accreditation Committee. Dr. Pecora was on staff at Point Pleasant Hospital and Paul Kimball Hospital, Lakewood. Dr. Pecora was a member of our Ocean County component and of the American Medical Association, and president of the Ocean County Chapter of the New Jersey Heart Association.

WILLIAM K. QUINTO

At the untimely age of 53, William Kuhlman Quinto, MD, passed away on March 9, 1991. Dr. Quinto was born in the Philippines, in 1938, and came to the United States in the early 1960s. Dr. Quinto earned his medical degree from the University of St. Thomas, Manila, Philippines, in 1957. He completed an internship at Perth Amboy General Hospital, residencies at Perth Amboy General Hospital and St. Vincent's Hospital, Staten Island, and a fellowship in cardiology at Raritan Bay Medical Center. He was licensed to practice medicine in the Philippines in 1962, and in New Jersey in 1969. An internist and cardiologist, Dr. Quinto maintained a practice in Metuchen and Edison and was an assistant attending at J.F. Kennedy Medical Center, Edison. He was a member of the AMA, and of our Middlesex County component.

GERTA SCHWARZ

Psychiatrist Gerta Schwarz, MD, passed away November 18, 1990, at the age of 76. Dr. Schwarz was born in Vienna, Austria, on June 12, 1914, and resided in Weehawken. She attended the University of Basel, Switzerland, earning her medical degree in 1939. After completing internships at St. Mary Hospital, Hoboken, and St. Francis Hospital, Greenville, South Carolina, and residencies in neuropsychiatry at Veterans Hospital, East Orange and Bellevue Hospital, New York City, Dr. Schwarz received her New Jersey medical license in 1959. Dr. Schwarz maintained a private practice in Weehawken; was affiliated with Bellevue Hospital, St. Mary Hospital, and Christ Hospital, Jersey City; and was a member of our Hudson County component and of the American Medical Association. She is survived by her husband, John Schwarz, MD.

ANTHONY M. SELLITTO

Anthony M. Sellitto, MD, died on February 21, 1991, after a brief illness. He was 83 years old. Born in 1907 in South Orange, Dr. Sellitto was awarded his medical degree from Jefferson Medical College of Philadelphia, Pennsylvania, in 1933; the following year he received his New Jersey medical license. After internships at Cumberland Hospital and Newark City Hospital, Dr. Sellitto completed postgraduate work at Mt. Sinai Hospital and New York Eye and Ear Hospital, both in Manhattan. An ophthalmologist, Dr. Sellitto maintained a private practice in South Orange and was the former medical director of the New Jersey State Commission for the Blind. During his lengthy career, Dr. Sellitto was affiliated with St. Mary's Hospital, Orange, as president, chief of staff, and chairman of the eye department; Newark Eye and Ear Hospital, as chief of staff and chairman of the eye department; and Clara Maass Medical Center, Belleville. He served as president of the New Jersey Academy of Ophthalmology and Otolaryngol-

ogy from 1975 to 1976 and as an associate clinical professor of ophthalmology at UMDNJ-New Jersey Medical School, Newark. A member of our Essex County component, Dr. Sellitto was a member of the National and International Colleges of Surgeons and of the American Board of Ophthalmology; he was a diplomate of the American Board of Ophthalmology. Dr. Sellitto retired to Spring Lake eight years ago.

E.L. SCHMACHER WEHMAN

Morristown ear, nose, and throat specialist for 35 years, Evelyn Louise Schmacher Wehman, MD, died February 13, 1991. Dr. Schmacher Wehman was born in Jersey City on January 30, 1911, and resided in Flushing, New York; Morris Plains; and Lima, Pennsylvania. After earning her medical degree from Woman's Medical College of Pennsylvania, Philadelphia, in 1935, she received her New Jersey medical license in 1947. Dr. Schmacher Wehman was associate attending at All Souls Hospital, Morristown and at Morristown Memorial Hospital. Dr. Schmacher Wehman was a member of our Morris County component and of the AMA; she was a diplomate of the American Board of Otolaryngology.

EDWARD A. WOLFSON

Born in New York City on February 4, 1926, Edward A. Wolfson, MD, passed away December 2, 1990. Dr. Wolfson earned his medical degree from Cornell University Medical College, New York, in 1953 and his master's degree in public health from Columbia University School of Public Health, in 1971. Dr. Wolfson received his New Jersey medical license in 1956. Specializing in internal medicine, Dr. Wolfson practiced in Paterson and was affiliated with St. Joseph's Hospital and Medical Center and Barnett Memorial Hospital Center, both in Paterson. Dr. Wolfson also was involved in medical education at Clin Campus at Binghamton, New York, and was a professor of medicine at Cornell University Medical College, New York, and at UMDNJ, Newark. Dr. Wolfson served as director of the Division of Drug Abuse at UMDNJ, Newark; a member of the Medical Society of New Jersey's Council on Public Relations, Committee on Drug Abuse, and Committee on Medical Education; a member of the Drug Abuse Task Force of the American Public Health Association, of the American Medical Association, and of our Passaic County component; president of the Passaic County Heart Association in 1965; a fellow of the American College of Physicians and of the American Academy of Preventive Medicine; and a diplomate of the American Board of Internal Medicine.

WILLIAM C. ZIEFERT

At the untimely age of 53, Maplewood resident William Charles Ziefert, MD, died on February 18, 1991. Dr. Ziefert was born in Brooklyn on June 30, 1937. After earning his medical degree from State University of New York Downstate Medical Center, Brooklyn, in 1962, Dr. Ziefert completed an internship and residency at Montefiore Hospital, New York. Dr. Ziefert received his New York and New Jersey medical licenses in 1963 and 1966, respectively. An internist, Dr. Ziefert practiced in Kearny and North Arlington; was attending at Saint Michael's Medical Center, Newark, and chief of medicine at West Hudson Hospital, Kearny; and an instructor at UMDNJ. Dr. Ziefert was a member of our Essex County component and of the AMA.

EDITORIAL CRITERIA

CONTENT

NEW JERSEY MEDICINE is the official organ of the Medical Society of New Jersey. The goals are educational and informational. All material published is copyrighted by the Medical Society of New Jersey.

The educational contents of each issue appear as scientific articles, based on research, original concepts relative to epidemiology of disease, and treatment methodology; case reports; review articles; clinical notes; state of the art reports; and special articles, that include evaluations, policy and position papers, and reviews of nonscientific subjects. Other topics include professional liability commentary; critical narration; medical history; pediatric briefs; nutrition update; and opinions. Editorials are prepared by the editor and by guest contributors on timely and relevant subjects. The Doctors' Notebook section contains organizational and administrative items from the Medical Society of New Jersey and from the community. Letters to the editor and book reviews are welcome and will be published as space permits.

The principal aim in the preparation of a contribution should be relevance to diagnosis and treatment and to the education of patients and professionals. Preference will be given to authors from New Jersey and to out-of-state lecturers submitting a suitable manuscript based on a presentation made to an audience in New Jersey.

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SPECIFICATIONS

Submit two manuscripts that must be typewritten and double spaced on 8½" by 11" paper. Statistical methods used in articles should be identified.

The title page should include the full name, degrees, and affiliations of all authors, and the name and address of the author to whom reprint requests and correspondence should be sent.

The author should submit a 30-word abstract to be used at the beginning of the article.

Tables must be typewritten and double spaced on separate 8½" by 11" sheets, with a title and number. Symbols for units should be confined to column headings, and abbreviations should be kept to a minimum.

Illustrations should be professional quality, black-and-white glossy prints. The name of the author, figure number, and the top of the figure should be noted on a label attached to the back of each illustration. When photographs of patients are used, the subjects should not be identifiable or publication permission, signed by the subject or responsible person, must be included with the photograph. Material taken from other publications must give credit to the source.

Generic names should be used with proprietary names indicated parenthetically or as a footnote with the first use of the generic name. Proprietary names of devices should be indicated by the registration symbol—®.

The summary of the article should not exceed 250 words; it should contain essential facts.

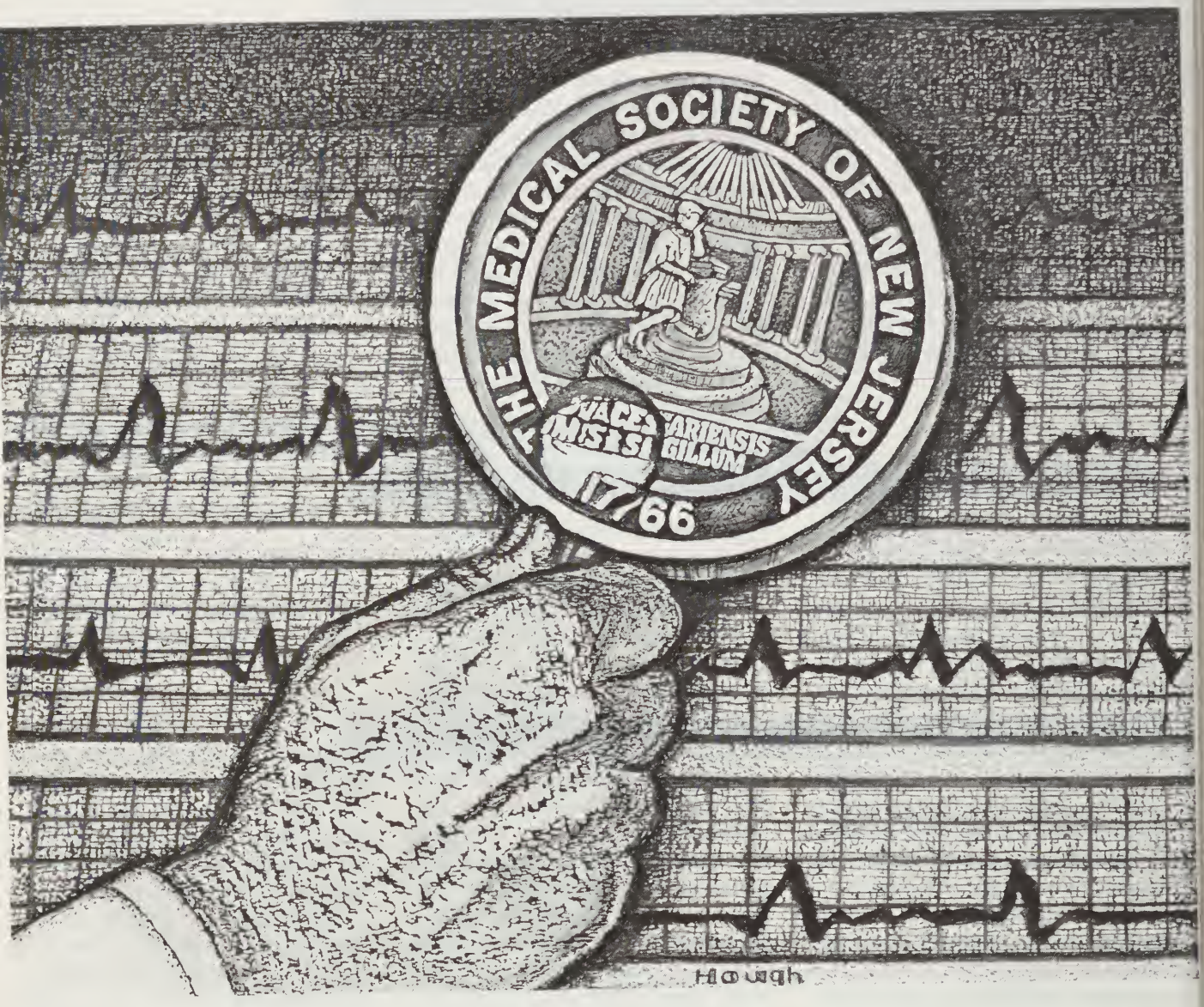
References should not exceed 35 citations except in review articles, and should be cited consecutively by numbers in parentheses at the end of the sentence. The style of *NEW JERSEY MEDICINE* is that of *Index Medicus:*

1. Goldwyn RM: Subcutaneous mastectomy. *NJ MED* 74:1050-1052, 1977.

PUBLICATION POLICY

Receipt of each manuscript will be acknowledged; the paper will be referred to the Editorial Board. Final decision is reserved for the editor. No direct contact between the reviewers and the authors will be permitted.

All communications should be sent to *NEW JERSEY MEDICINE*, MSNJ, 2 Princess Road, Lawrenceville, NJ 08648. □



1991 MSNJ Transactions

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1990 Transactions

The House of Delegates approved the Transactions of the 1990 Annual Meeting, as published in ***NEW JERSEY MEDICINE***.

Action To Limit Debate

The House of Delegates agreed, upon motion, that no one may speak more than once on any given subject except in rebuttal or by express permission of the House, and that floor time in each instance shall be limited to four minutes unless exception is made by the House.

Reports and Resolutions

Reports and resolutions and the actions, thereon, are included under the Reference Committee to which they were assigned. The House takes action only on the resolved sections of a resolution.

Presidential Appointments

Speaker: **Karl T. Franzoni, MD, Mercer**
Vice-Speaker: **Edward A. Schauer, MD, Monmouth**
Chief Sergeant-at-Arms: **Frank L. Redo, MD, Salem**
Sergeants-at-Arms: **Anthony C. Barbara, MD, Bergen; Timothy M. Hosea, MD, Middlesex; Carlo Porcaro, MD, Essex; Robert I. Salasin, MD, Cape May**
Chief Teller: **George T. Hare, MD, Camden**
Chairman of Reference Committee on Credentials: **Carl Restivo, Jr, MD, Hudson**

PRESIDENT/CHAIRMAN OF THE BOARD OF TRUSTEES

Douglas M. Costabile, MD
Reference Committee "A"

A year has passed with the turmoil that has presented itself to your Board of Trustees and the Medical Society of New Jersey. It seemed that as soon as one annoyance was under control, another would rear its ugly head. However, with all against them, the physicians of this state continue to administer high-quality care to their patients.

LITIGATION

The State Board of Physical Therapy won the decision to allow it to conduct examinations and instructions—with reservations that they must not change the therapy recommended and prescribed for patients by their physicians.

We currently are awaiting the decision of the judge on our suit against the commissioner of insurance on malpractice liability surcharge and also the no-fault fee schedule.

We now are in litigation over the use of physician assistants in which the State Board of Medical Examiners gave the signal to set up pilot projects.

LEGISLATIVE/REGULATORY ACTIVITY

As president of your Medical Society, I have been in attendance at several hearings. I presented a statement before Senator Codey's committee giving the salient features that the Board of Trustees felt should be brought to the attention of the legislators. Several other doctors spoke, yet no recognition was noted in the newspapers the following day. Assemblyman Doria also had a hearing on the Uncompensated Care Trust Fund. Mr. Maressa addressed the group, but again, no recognition that the Medical Society was present. The Medical Society of New Jersey was present. The Medical Society of New Jersey will continue to be present on all medical matters that come before the legislators.

Your executive committee will return to Washington, DC to meet with our federal legislators on medical matters this spring or fall.

A letter was sent to President Bush asking that the inspector general of the Department of Health and Human Services be relieved of his duties because of unwarranted and inappropriate behavior toward doctors.

MEDICAL INTER-INSURANCE EXCHANGE OF NEW JERSEY

There have been several improvements since the Board of Directors conducted an extensive review of the procedures of the Medical Inter-Insurance Exchange of New Jersey (MIIENJ). Following the death of Peter Sweetland, a new chairman and chief executive officer was appointed. Mr. Daniel Goldberg was named by the Board of Directors and the Board of Governors. Mr. Vincent A. Maressa was named chairman of the Board of Directors. It was a decision by both Boards that the necessary subordinated loans be eliminated on new policies and a request has been made to the Insurance Department to redeem those subordinated loans that are outstanding. The 1991 malpractice rates indicated 3.9 percent overall decrease. We currently have a Strategic Planning Committee of MIIENJ that should be able to select other areas of involvement for your liability carrier.

PENNSYLVANIA BLUE SHIELD/MEDICARE

It is my impression that the situation with Pennsylvania Blue Shield (PBS) has improved with the ongoing conversations that have taken place this past year. There still are areas that may need improvement. A committee of doctors and members of PBS have met on one occasion. Although the Health Care Financing Administration (HCFA) was present for only a short time, I believe they will remain present for the entire meeting.

PBS has agreed to pay for "assisting at herniorrhaphy procedures" requiring an assistant.

We again invite Dr. Monahan and Mr. Kiley to our monthly Board meetings to answer questions that may arise.

OTHER ITEMS

This past year, I have been on the road at the beck and call of any county society that wanted my presence. Many of the discussions were related to AMA affiliation. As it

stands, unless we have more members, we very well may lose a delegate and an alternate delegate. Another aspect of concern is JEMPAC and MEDAC. We have some very important elections in the near future—and money does talk. We must continue to be politically minded for the future of our practice and for our patients.

Our Board of Trustees welcomes all members of the Medical Society at monthly meetings to discuss any problems. In assisting members, we now have an 800 number available for use.

CONCLUSION

I would like to thank the Board of Trustees for their help in making the necessary determinations for the welfare of the physicians of this Society and their patients. A sincere thanks also goes to those committee and council members who have interceded on behalf of the doctors of this great Society. I am grateful for the opportunity of having served you this past year.

[redacted]

The Reference Committee recommended that the report be filed.

HOUSE ACTION: Adopted. The report was filed.

JUDICIAL COUNCIL

Paul H. Steel, MD
Reference Committee "A"

The Judicial Council presents a summary of its operations and those of county judicial committees for the period May 1990, through February 1991.

By Judicial Committees

Complaints reported as disposed of	75
Alleging:	
Dissatisfaction concerning fees	23
Dissatisfaction concerning medical procedures	16
Unprofessional conduct	20
Dissatisfaction concerning professional ethics	16

By Judicial Council

Meetings held	2
Official communications acted upon	120
Appeal hearings requested	2
Appeal hearings granted	1
Formal opinions revised (Opinion #14)	1

Interest Charges. Revised November 8, 1990. A physician who has experienced problems with delinquent accounts may properly choose to add interest or other reasonable billing charges to delinquent accounts. The patient must be notified in advance of the interest or service charges by means of posting a notice in the waiting room, the distribution of leaflets in the office, and appropriate notations on billing statements. The physician must comply with state law that limits interest to the rate approved by the State Supreme Court. Please note that the prescribed rates are to be applied on a calendar year basis, i.e. from January 1 through December 31, rather than on a fiscal year basis.

The rate for calendar year 1990 is 8.0 percent. The rate for calendar year 1991 will be 8.57 percent. Physicians are encouraged to make exceptions in hardship cases.

The Council does not believe it is appropriate to add attorneys' fees, court costs, or collection costs to the amount owed. If, however, costs and fees are added by court determination, it is appropriate to collect them.

Legal Liabilities/County Judicial Committees. Correspondence was received from the Morris County Medical Society regarding how county medical societies can deal with the growing expenses involved in administering their regulations. Included also was a request for MSNJ to change its bylaws and rules and regulations governing county judicial committees: to preclude legal representation at the local level; or eliminate peer review of complaints completely and refer all cases directly to the State Board of Medical Examiners; or seek protective legislation for all county society judicial committees.

Further correspondence was received from the Monmouth County Medical Society supporting Morris County in their concern for legal liabilities.

At the writing of this report, a meeting is being scheduled to discuss these issues. Four surrounding state medical societies also have been contacted to provide input on their judicial systems.

The disposition of the Judicial Council regarding this subject will be published in a Judicial Council Supplemental Report.

[redacted]

The Reference Committee recommended that the report be filed.
HOUSE ACTION: Adopted. The report was filed.

SUPPLEMENTAL REPORT #1: JUDICIAL COUNCIL

Paul H. Steel, MD
Reference Committee "A"

The Judicial Council presents a summary of additional actions taken after compilation of its Annual Report.

Referral from MSNJ Board of Trustees (October 21, 1990): Legal liabilities/county judicial committees. The Monmouth County Medical Society and Morris County Medical Society have written to the Board regarding judicial mechanism. The Board of Trustees has asked the Council for its recommendation in this regard. The Council contacted the states of Pennsylvania, Maryland, Connecticut, and New York. These medical societies operate systems virtually identical to ours. Like us, they have had an episodic problem at a given county society. None of these state societies are contemplating any changes. The concepts suggested by the two counties are discussed below.

Legal Representation at Local Level. Both county medical societies recommended that we preclude legal representation at the local level. That concept is not acceptable to the Council nor should it be to the Society that believes and stresses fundamental fairness to physicians under review.

Eliminate Peer Review and Refer Directly to the State Board of Medical Examiners. Monmouth County did not agree with Morris County in this regard and neither does the Judicial Council; such a course would be imprudent and an abdication of the Society's responsibility to its membership and the public.

Seek Protective Legislation for all County Judicial Committees. Morris and Monmouth Counties agree on this point. The Council notes, however, that no action is necessary. The Medical Society of New Jersey requested statutory immunity for the counties, itself, and all other hospital committees and professional society peer review committees. A-4058 was introduced and signed into law as Chapter 507 of the laws of 1985. It now appears as NJSA 2A:84A-22.10 and grants immunity for all reviews and actions taken without malice and based upon reasonable belief after reasonable investigation.

The Council, therefore, has concluded that the mechanism should continue as presently constituted. Mr. Maressa has advised us that he can refer county societies to law firms that will assist judicial committees at very reasonable rates on an ad hoc basis.

The Council recommends that no further action be taken and that county societies contact Mr. Maressa if they are interested in representation. (The Board of Trustees concurred in this decision on April 7, 1991.) □

The Reference Committee recommended Supplemental Report #1 be filed.

HOUSE ACTION: Adopted. The Supplemental Report #1 was filed.

AMA DELEGATION

Karl T. Franzoni, MD
(Reference Committee "A")

I again am grateful for the opportunity to summarize the activities of your delegation throughout 1990.

COMPOSITION OF AMA HOUSE OF DELEGATES

There are 435 delegates, with the following composition: 348 delegates representing state medical associations; 77 delegates representing national medical specialty societies; and 10 delegates representing medical students, resident physicians, hospital medical staffs, medical schools, young physicians, Army, Air Force, Navy, United States Public Health Services, and the Veterans Administration.

The volume of material addressed and resolved at both Annual and Interim Meetings continues to increase. At the recent Interim Meeting in Orlando, 194 resolutions and 106 Board and Council reports were considered.

HIGHLIGHTS

A. Budget and Dues. The Association's operating revenues are estimated at $189 million, with operating expenses anticipated at $186 million. Annual dues will remain at $400 for 1991.

B. Health Access America. Americans desire access to a health care system that delivers quality services to every American at affordable prices. And, we want a system that is easy to understand and use.

The American health care system is now under review by a number of groups. These reviews are being undertaken because many Americans lack health insurance coverage. The increasing cost of health insurance for many Americans who have coverage, particularly the increasing costs within the Medicare program and employment-related coverage, is of increasing concern.

The physicians of America, represented by the American Medical Association, believe that improvements need to be made promptly to our health care system, especially addressing the access and cost problems.

Thus, the AMA has developed a proposal to ensure access to the benefits of the American health care system for every citizen. The diversity of those without insurance necessitates a broad-based approach, utilizing both the public and private sectors, to fashion solutions. Many difficult decisions regarding the allocation of society's resources will need to be made to accomplish the goal of extending access to everyone.

It is a challenge. A challenge to decide whether such expanded access is something society is willing to pay for, to transfer revenues from other programs, and to provide sufficient support within the legislative process to bring about concrete results.

The AMA believes that a national dialogue must take place to address these challenges and critical issues. The problems facing the American health care system cannot be solved by any one organization. A collaborative process should be pursued, working with government and others.

The AMA is committed to the process of debate and negotiation. In the months ahead, we will meet with other health care providers and representatives of government, labor, business, the insurance industry, and other interested groups to develop refinements and modifications to our proposal as needed.

America's physicians, committed to delivering quality care, want to work with all decision makers toward positive solutions. We recognize that, primarily due to cost constraints, priorities will need to be established to accomplish different elements of our proposed plan. Our proposal lays out an outline for action—and the time for action is now.

In developing the specific provisions of this proposal, the AMA has considered what it believes are a number of fundamental principles that should underscore the national discussion on improving our health care system. These fundamental principles are:

- Improvements to the American health care system should preserve the strengths of our current system;

- Affordable coverage for appropriate health care should be available to all Americans, regardless of income;
- Particular efforts are needed to assure continued access by the elderly to affordable health care services;
- Health care services should be delivered with high quality at appropriate costs;
- Patients should be free to determine from whom and the manner that health care benefits are delivered;
- All physicians should be committed to the highest ethical standards in the delivery of care to patients.

The specific provisions of the AMA proposal build on these six principles. The specific provisions are designed to accomplish the goal of expanding access to affordable, quality health care for all Americans.

All physicians should familiarize themselves with the details of this endeavor, and actively sponsor its development and acceptance by our patients.

C. AMA Fiscal Irregularities. The fiscal irregularities that tarnished the image of the AMA during 1989-1990 have been fully addressed, and mechanisms to assure nonrecurrence are in place. The AMA has adopted a "lean and mean" focus with efforts and resources directed to its primary mission of physician representation.

James S. Todd, MD, AMA's executive vice-president, stated that "because the AMA cannot be all things to all people, it must do fewer things better."

D. Fate of New Jersey Resolutions.

1. *Medicare Billing Requirement.* New Jersey's resolution called for the AMA to seek immediate repeal of the Omnibus Budget Reconciliation Act of 1989 mandatory claim form completion requirement, and, if such an effort is not successful, to seek additional payment for physician expenses associated with this provision.

During the reference committee hearing, several physicians spoke of the need to allow the Board sufficient tactical flexibility on this issue. Therefore, consistent with longstanding AMA opposition to Medicare charge limits, the House adopted a substitute resolution that incorporated New Jersey's resolution.

2. *Interim Meeting Location.* This resolution asked that future AMA Interim Meetings be held in Washington, DC, pending the fulfillment of existing contractual agreements.

The reference committee also considered proposed amendments that included having either the Annual or Interim Meeting in Washington, DC, or holding the Leadership Conference in Washington, DC.

The reference committee decided that while some other type of AMA meeting or state PAC meeting in Washington, DC may be effective, it is not in the best interest of the AMA to schedule a House meeting in Washington, DC, on an annual basis. The House supported that position.

3. *Medically Unnecessary Services (Medicare).* The resolution was placed on the consent calendar and adopted.

4. *Gender Exploitation in the Workplace.* The resolution was accepted as a reaffirmation of pre-existing AMA policy.

5. *Tax Deductions for Uncompensated Care.* The 1990 MSNJ House of Delegates referred this resolution to the Board of Trustees for appropriate action. AMA policy does not support a special income tax deduction for providing medical care to the indigent. This issue previously had been evaluated by the AMA Council on Medical Service. The Council concluded that the concept is not appropriate, and some of the reasons cited in reaching this conclusion include:

- Tax law recognizes deductions for donations of money and property that may be accurately evaluated to determine value, and not for more intangible items such as time and services;
- For a physician to provide charity care directly to the indigent would require extensive documentation and administrative efforts;
- Charity donations are channeled through charitable organizations, and physicians generally do not provide care under the rubric of charitable organizations;
- The Constitution probably would not allow a tax deduction of this nature to be limited for services provided by physicians, and the potential for abuse could be substantial; and

- The federal and state revenue loss from additional tax deductions for all uncompensated medical and health care services would result in decreased revenues received by the government, and would further contribute to the deficit.

The AMA supports communicating to the public the problem of uncompensated care and the ever-increasing regulations involving such care, as well as the detrimental effect that uncompensated care has on the availability of necessary health care services to many citizens; and publicizing the programs currently instituted to address uncompensated care, and pursuing additional solutions for dealing with the problem of uncompensated care.

6. *No to National Health Insurance.* This resolution was referred to the AMA Delegation for report back to the Board.

The Board was advised that AMA policy reaffirms the following statement of principles as a positive articulation of the Association's opposition to socialized or nationalized health care:

- Free market competition among all modes of health care delivery and financing, with the growth of any one system determined by the number of people who prefer that mode of delivery, and not determined by preferential federal subsidy, regulations, or promotion.
- Freedom of patients to select and to change their physician or medical care plan, including those patients whose care is financed through Medicaid or other tax-supported programs, recognizing that in the choice of some plans, the patient is accepting limitations in the free choice of medical services.
- Full and clear information to consumers on the provisions and benefits offered by alternative medical care and health benefit plans, so that the choice of a source of medical care delivery is an informed one.
- Freedom of physicians to choose whom they will serve, to establish their fees at a level that they believe fairly reflects the value of their services, to participate or not participate in a particular insurance plan or method of payment, and to accept or decline a third-party allowance as payment in full for a service.
- Inclusion in all methods of medical care payment of mechanisms to foster increased cost awareness by both providers and recipients of service, that could include patient cost sharing in an amount that does not preclude access to needed care, deferral by physicians of a specified portion of fee income, and voluntary professionally directed peer review.
- The use of tax incentives to encourage provision of specified adequate benefits, including catastrophic expense protection, in health benefit plans.
- The expansion of adequate health expense protection to the presently uninsured, through formation of insurance risk pools in each state, sliding-scale vouchers to help those with marginal incomes purchase pool coverage, development of state funds for reimbursing providers of uncompensated care, tax incentives to assist small employers in buying health insurance coverage, and reform of the Medicaid program to provide uniform adequate benefits to all persons with incomes below the poverty level.
- Replacing the present Medicare program with a system developed by the AMA of prefunded vouchers to older persons to purchase health insurance with comprehensive benefits, including catastrophic coverage.
- Development of improved methods of financing long-term care expense through a combination of private and public resources, including encouragement of privately prefunded long-term care financing to the extent that personal income permits, assurance of access to needed services when personal resources are inadequate to finance needed care, and promotion of family caregiving.

7. *Lift Chair—Medicare Reimbursement.* This resolution asks that the AMA Council on Scientific Affairs investigate the cost, appropriateness, and quality of lift chair devices.

The House adopted a substitute resolution resolving that the AMA monitor and assist physicians and patients during implementation of provisions of the Omnibus Budget Reconciliation Act of 1990; that limit Medicare payment for seat lift chairs to the seat lift mechanism only and not the chair, and that forbid durable medical equipment suppliers from providing physicians or Medicare beneficiaries with completed or partially completed documentation of medical necessity.

8. *Resignation of Health and Human Services Inspector General Kusserow.* The

substitute resolution adopted by the House urges continuation of the AMA's efforts to seek Richard Kusserow's resignation or dismissal, and encourages state medical societies, national medical specialty organizations, auxiliary organizations, and individual physicians to write President Bush, Doctor Sullivan, and members of Congress in support of the AMA's action.

9. *HCFA Precertification for Emergency Surgery.* This resolution seeks to petition the Health Care Financing Administration (HCFA) to repeal existing peer review organization (PRO) regulations requiring preadmission/preprocedure approval. The House approved a more comprehensive substitute resolution stating that:

- Blanket preadmission review of all or the majority of hospital admissions does not improve the quality of care and should not be mandated by government, other payors, or hospitals.
- Policies for review should be established by state or local physician review committees and the actual review should be performed by physicians, or under the close supervision of physicians.
- All preadmission review programs should provide for immediate hospitalization, without prior authorization or subsequent denial of payment based on lack of such authorization, of any patient whose treating physician determines the admission to be of an emergency nature.

10. *Physician Notification Under PRO Review.* The action called for in the New Jersey resolution was accomplished.

11. *Lack of PRO Cost Effectiveness.* The resolution was adopted on the consent calendar.

12./13. *National Practitioner Data Bank—Adverse Applicant Information* and *National Practitioner Data Bank—Response Time.* The House received a total of six resolutions associated with the National Practitioner Data Bank, including two resolutions from New Jersey. The Reference Committee recommended a substitute resolution that was adopted along with a resolution submitted by the Hospital Medical Staff Section.

The delegates voted to ask the AMA:

- To continue to work with the Department of Health and Human Services (HHS) to ensure that the National Practitioner Data Bank does not collect nor release information regarding the denial of specific clinical privileges based solely on failure to meet hospital-established minimal criteria, i.e. level of professional liability coverage, board certification, not related to a physician's competence or professional conduct;
- To continue to work with HHS to revise the current Data Bank dispute process to accelerate a physician's opportunity to attach an explanation or statement to a disputed report;
- To work with HHS to establish an appropriate response time for hospital inquiries to the Data Bank;
- To work with HHS to establish a mechanism to inform physicians when an inquiry to the Data Bank has been made;
- To reaffirm its policy that reports, other than licensure revocation, in the Data Bank should be purged after five years;
- To support efforts to require the same Data Bank reporting requirements for physicians, dentists, and other licensed health care practitioners;
- To reaffirm its policy and use all necessary efforts to direct the National Practitioner Data Bank to send all notifications to physicians by certified mail, return receipt requested; and
- To use all necessary efforts at the federal level to direct the National Practitioner Data Bank to begin the 60-day appeal process from the date the physician receives notification.

14. *Drug Abuse.* The House adopted a resolution encouraging every physician to make a commitment to join his community in attempting to eliminate drug abuse by the year 2000. That said commitment should encourage involvement in at least one of the following roles: donation of money to any drug abuse prevention program; donation of time to talk to local civic groups, schools, religious institutions, and other appropriate groups; join or organize local groups dedicated to drug abuse prevention; talk to youth groups about brain damage and other deleterious effects of drug abuse; and educate and support legislators, office holders, and local leaders toward ending the drug abuse crisis.

E. Election to National Office. The 1990 election was a special one of accomplishment in the national office arena. Our own Palma E. Formica, MD, succeeded in her quest to serve on the AMA Board of Trustees. Pam won a resounding victory to a full three-year term. The AMA House of Delegates demonstrated its wisdom in recognizing the attributes of leadership essential for this office, and so manifestly exhibited by Pam Formica. The participation of your delegation members in her campaign's successful outcome was outstanding.

MSNJ Honorary Fellow James S. Todd, MD, replaced James Sammons, MD, as executive vice-president of the American Medical Association. Doctor Todd wishes to have New Jersey physicians repeatedly reminded of his gratitude to MSNJ for all previous efforts on his behalf that made his selection for this singular honor possible.

Robert J. Weierman, MD, was elected to a two-year term as secretary of the AMA-Hospital Medical Staff Section Governing Council. He previously had served as member-at-large.

F. Recruitment and Retention of Members. All physicians are encouraged to assume an enhanced interest in "one-on-one" efforts to assure the accomplishment of membership expansion. Goals and objectives of county, state, and national organizations are not and should not be mutually exclusive, but complementary. Participation in the "House of Medicine" in its entirety is desirable. The diverse issues faced by our reversed profession should serve as a meaningful stimulus to greater unity.

CONCLUSION

I am pleased to confirm that the members of your delegation to the AMA bring intelligence, diligence, and a dedicated work ethic to their responsibility in representing you. I reaffirm that they encourage you to contact them directly of your concerns. They are available by invitation to address any forums you may consider appropriate. I also encourage active pursuit by MSNJ physicians interested in serving as delegation members.

[redacted]

The Reference Committee noted that there will be no increase in AMA dues for 1991.

The Reference Committee recommended that the report be filed, with commendation to the AMA Delegation.

HOUSE ACTION: Adopted. The report was filed with commendation to the AMA Delegation.

COMMITTEE ON LONG-RANGE PLANNING AND DEVELOPMENT

Edward A. Schauer, MD
Reference Committee "A"

The Committee on Long-Range Planning and Development met on January 23, 1991, at the executive offices of the Medical Society of New Jersey in Lawrenceville. The Committee reviewed the strategic plan developed in March 1990 and the summarization of the imperatives.

The Committee studied the frequency of meetings of all of the Medical Society's councils and committees during the past four years. After discussion, the Committee felt that to make decisions with reference to future activities of councils and committees, the Committee would like to have the opinions of the members via a questionnaire. This questionnaire would ask a committee/council member of his opinions concerning objectives, achievements, and suggestions on the function of the committee or council. As a result, a questionnaire was drafted and sent to all of the council/committee members. When the questionnaires are returned, they will be evaluated by the Committee on Long-Range Planning and Development.

While the Committee will monitor implementation of the strategic plan annually, it will conduct an indepth analysis every two to three years. Its observations and recommendations will be reported to the Board of Trustees.

The Reference Committee recommended that the report be filed.

HOUSE ACTION: Adopted. The report was filed.

COMMITTEE ON PHYSICIANS' HEALTH

Simon Murray, MD
(Reference Committee "A")

The major activity of the Physicians' Health Program continues to be the identification, rehabilitation, and monitoring of New Jersey physicians who are victims of alcoholism, drug abuse, mental illness, dementia, or disabling physical conditions.

The recognition and acceptance of the program continues to grow as more and more successful physicians return to the ranks of the profession.

A significant development over the past year was the establishment of a contactual relation with the New Jersey Podiatric Society to provide program services to the members of their Society.

The Tables demonstrate the statistics and demographics of our program activities. Nothing in these numbers informs you of the personal success of the individual physicians that these data catalogue.

We work with an extremely precious commodity, the lives and careers of a large number of caring, capable physicians who are the victims of a variety of diseases that they did not

Table 1. County statistical breakdown.

	Year									
County	1982	1983	1984	1985	1986	1987	1988	1989	1990	Total
Atlantic	2	1	1	4	3	0	0	2	2	15
Bergen	5	8	6	5	6	2	6	8	13	59
Burlington	2	4	1	3	4	1	1	2	1	19
Camden	5	9	6	4	6	6	5	8	3	52
Cape May	0	5	2	1	1	3	0	1	0	13
Cumberland	1	2	1	2	1	0	1	0	0	8
Essex	3	13	9	5	5	4	10	13	4	66
Gloucester	0	2	1	1	0	1	1	0	1	7
Hudson	3	5	1	2	3	1	4	2	3	24
Hunterdon	1	0	3	1	2	2	0	2	0	11
Mercer	4	5	10	11	3	5	2	6	2	48
Middlesex	4	3	2	5	2	2	5	6	4	33
Monmouth	8	7	6	9	6	5	7	6	8	62
Morris	2	4	2	3	10	5	1	6	5	38
Ocean	0	3	4	1	4	0	2	1	4	19
Passaic	2	3	5	3	2	6	3	5	4	33
Salem	0	0	0	0	0	0	1	1	0	2
Somerset	2	0	2	0	2	1	0	1	1	9
Sussex	1	0	0	2	2	3	1	1	0	10
Union	2	4	3	10	5	4	1	2	2	33
Warren	1	1	0	1	1	2	0	2	1	9
Out-of-State	0	2	6	10	8	4	1	5	7	43
Total	48	81	71	83	76	57	52	80	65	613

Table 2. Breakdown by medical degree.

Degree	Year 1982	1983	1984	1985	1986	1987	1988	1989	1990	Total
MD	40	67	62	61	66	51	42	69	50	508
DO	7	9	2	9	5	2	4	2	5	45
VMD	0	1	3	3	0	1	0	2	4	14
DPM*	0	0	0	0	0	0	0	0	1	1
Other	1	4	4	10	5	3	6	7	5	45
Annual Total	48	81	71	83	76	57	52	80	65	613

*Doctors of podiatric medicine were not officially part of the Physicians' Health Program until October 1990.

Table 3. Breakdown by male/female.

Male	46	78	66	73	67	48	44	72	57	551
Female	2	3	5	10	9	9	8	8	8	62
Annual Total	48	81	71	83	76	57	52	80	65	613

Table 4. Statistical report, September 7, 1982—December 31, 1990.

	Year 1982	1983	1984	1985	1986	1987	1988	1989	1990	Total
Primary Impairment										
Alcohol	14	40	19	31	31	18	16	22	25	216
Drugs	25	16	22	24	25	20	21	24	18	195
Psychiatric	7	18	19	19	14	15	9	18	18	137
Senility	1	5	3	2	0	0	1	1	2	15
Personality Disorders	0	1	0	0	2	1	0	2	0	6
Other	1	1	8	7	4	3	5	13	2	44
Annual Total	48	81	71	83	76	57	52	80	65	613

want and often do not understand. The many positive changes in their lives resulting from recovery are what make our job worthwhile.

The Reference Committee recommended that the report be filed.
HOUSE ACTION: Adopted. The report was filed.

RESOLUTION #5

Introduced by: Hudson County Medical Society
Subject: Uncompensated Care
Referred to: Reference Committee "A"

Whereas, physicians treating indigent, uninsured patients have not been compensated for their delivery of medical services; and

Whereas, the magnitude of the problem of uncompensated care continues to increase as the number of indigent and uninsured patients grows; and

Whereas, the Uncompensated Care Trust Fund of the state of New Jersey provides full compensation to hospitals for their services to uninsured, indigent patients; now therefore be it

~~**Resolved,** that the Medical Society of New Jersey develop a system of payment to physicians for the treatment and care of uninsured patients and petition the New Jersey Hospital Association and the state government to implement such a system.~~

Resolved, that the Medical Society of New Jersey continue exploration of appropriate mechanisms for compensation of physicians for the care of uninsured patients.

[redacted]

Because of their similarity, the Reference Committee combined consideration of Resolutions #5 and #7. However, it was felt that the Resolutions do not comprehensively address the issue. Of particular concern to the Reference Committee, was access to health care for the uninsured.

The Reference Committee recommended that the following Substitute Resolution for Resolutions #5 and #7 be adopted.

Resolved, that the House of Delegates endorse "Health Access New Jersey" and take whatever steps are necessary to implement that policy.

HOUSE ACTION: Not adopted. Resolution #5 was adopted as amended by the House.

RESOLUTION #6

Introduced by: Hudson County Medical Society
Subject: Term of AMA Delegates and Alternates
Referred to: Reference Committee "A"

Whereas, the bylaws of the Medical Society of New Jersey specify a maximum tenure of 12 years as an AMA delegate and/or an alternate delegate; and

Whereas, the success of a delegation is closely related to the visibility of its members; and

Whereas, in a body that meets only twice a year, widespread recognition can be achieved only after several years; and

Whereas, no other state medical society has a similar restriction on its AMA delegation tenure; now therefore be it

Resolved, that the restriction on tenure of the AMA delegation be removed; and be it further

Resolved, that the bylaws be amended accordingly.

[redacted]

The majority of the comments expressed before the Reference Committee were not in favor of the Resolution.

The Reference Committee recommended that Resolution #6 be rejected.

HOUSE ACTION: Adopted. Resolution #6 was rejected.

RESOLUTION #7

Introduced by: Ocean County Medical Society
Subject: Physician Uncompensated Care Fund
Referred to: Reference Committee "A"

Whereas, in New Jersey, Medicaid funding for physician services is lower than in any other state in the United States, and has not been substantially increased for over 15 years; and

Whereas, the PIP schedule of fees for automobile accident-related injuries is fixed and does not permit balance billing; and

Whereas, the Health Care Financing Administration (HCFA) has frozen physician fees for seven years and recently has severely cut the schedule of fees, in many cases rolling them back to fees charged in the mid 1970s; and

Whereas, the federal budget for fiscal year 1992 contains plans for significant cuts in payment for physician services; and

Whereas, HMOs, IPAs, and PPOs have forced physicians to discount customary reasonable fees; and

Whereas, the governor and members of the state Legislature are intent in passing a mandated Medicare assignment bill; and

Whereas, the burgeoning interference of bureaucracy and soaring malpractice rates have led to a disproportionate increase in the cost of running a medical practice; and

Whereas, the sum of the foregoing factors has had a cumulative negative effect on the ability of physicians to render pro bono services to the indigent; now therefore be it

Resolved, that the Medical Society of New Jersey endorse "Health Access New Jersey" and take whatever steps are necessary to implement that policy; and be it further

Resolved, that the Medical Society of New Jersey actively pursue the introduction of legislation to provide remuneration for physician services currently rendered pro bono in hospitals throughout the state.

[redacted]

Because of their similarity, the Reference Committee combined consideration of Resolutions #5 and #7. However, it was felt that the Resolutions do not comprehensively address the issue. Of particular concern to the Reference Committee was access to health care for the uninsured.

The Reference Committee recommended that the following Substitute Resolution be adopted:

Resolved, that the House of Delegates endorse "Health Access New Jersey" and take whatever steps are necessary to implement that policy.

- HOUSE ACTION: Not adopted. Resolution #7 was adopted as amended by the House of Delegates (addition of first resolved).

SECRETARY

Bernard Robins, MD
(Reference Committee "B")

The office of the Secretary has continued its usual routines, primarily involving maintenance of membership records, correspondence, minutes of Board of Trustees' meetings, telephone inquiries, and completion of numerous questionnaires originating from various sources. During the administrative year, the secretary attended the meetings of the Board of Trustees and the several committees of which he is chairman, member, or advisor.

Membership (as of December 31, 1990)

Active	Paid	7,361	
	Exempt	824	
Resident	Paid	135	8,320***
*Associate	Paid		27
**Affiliate	Paid		78
	Exempt		5

State Emeritus	1,127
Total of above	9,557
Provisional Residents (six months)	14
State Honorary	2
New and Reinstated Members	
Active	642
Resident	41
*Associate	14
Transfers within the state	43
Transfers out-of-state and resignations	62
Members deceased	129
Members dropped	340

Active:		
a. Nonpayment of dues	262	
b. Did not comply with bylaw requirements regarding continuing medical education, whose credits were due in 1989	22	
Resident (nonpayment of dues)		39
*Associate (nonpayment of dues)		12
**Affiliate (nonpayment of dues)		5

*Associate membership (nonlicensed in New Jersey) designates interns and residents.
**Affiliate membership designates physicians who no longer practice in New Jersey.
***Adjusted for transfers out-of-state, resignations, and deaths.

A comparison of December 31, 1989, to December 31, 1990, by county shows the following net changes of active paid membership:

Atlantic	+ 3	Gloucester	- 2	Ocean	+ 15
Bergen	- 22	Hudson	- 30	Passaic	- 5
Burlington	- 2	Hunterdon	+ 2	Salem	- 1
Camden	+ 22	Mercer	+ 9	Somerset	+ 2
Cape May	+ 1	Middlesex	- 10	Sussex	+ 6
Cumberland	- 7	Monmouth	- 6	Union	- 10
Essex	- 50	Morris	+ 12	Warren	- 4

AMA Membership. A total of 8,917 New Jersey licensed physicians maintain active membership in the AMA. The Society's representation in the AMA House of Delegates stands at ten delegates—one for each thousand members, or fraction thereof.

Credentials. The Committee on Credentials reviewed and acted upon membership applications and their supporting credentials as submitted through the component societies. The statistical breakdown in the Table reflects the Committee's activities during the period February 1, 1990, through January 31, 1991.

Received:	Provisional *Associate	Residents Licensed	Active	Grand Total
	21	29	324	374

Reviewed and found:	Provisional *Associate	Residents Licensed	Active	Grand Total
(A) Satisfactory	19	27	297	343
(B) Unsatisfactory	0	0	0	0
Pending	2	2	18	22
Withdrew	0	0	9	9
Grand Total	21	29	324	374

*Associate membership (nonlicensed in New Jersey) designates interns and residents.

The Committee extends appreciation to the directors and the secretaries of component societies, and to those who assist them, as well as the county credentials committees, for their cooperation in processing membership applications. It especially would be helpful to the Credentials Committee of the Medical Society of New Jersey if those who process credentials in the component societies would call specific attention to any deficiencies or questionable data being submitted on the application form. This procedure will help insure more accurate and speedy evaluation of credentials. The chairman wishes to thank his Committee members for their diligence and cooperation.

Membership Directory. The 1991 edition of the *Membership Directory* has been completed and distributed to all members. Additional copies of the *Membership Directory* are available, for a fee, by contacting Mrs. Joyce Guest at MSNJ headquarters, Lawrenceville. There were 2,318 copies of the 1989 edition sold to nonmembers.

The Reference Committee recommended that the report be filed.

HOUSE ACTION: Adopted. The report was filed.

TREASURER

Gerald H. Rozan, MD
(Reference Committee "B")

These interim financial statements, prepared in accordance with generally accepted accounting principles, reflect the financial position and results of operation of the Medical Society of New Jersey through February 28, 1991.

Since they are interim statements (the Society's fiscal year is June 1-May 31), the figures are unaudited. A complete audit will be conducted of the books of the Society as of May 31, 1991, and an audited report prepared as of that date. A complete audit was made, and copies sent to all county medical societies, as of May 31, 1990.

Medical Society of New Jersey
February 28, 1991
(Unaudited)

Assets		
Cash		$ 321,758
Investment in money market fund		3,013,614
Marketable securities (approximate market)		999,295
Accounts receivable—member assessments		468,213
Medical student loans (net allowance for doubtful loans of $20,000)		148,701
Property, Plant, and Equipment		
Land	$ 150,000	
Building and improvements	5,375,588	
Furniture and fixtures	551,260	
	6,076,848	
Less allowance for depreciation	(1,202,490)	4,874,358
Prepaid expenses		117,277
Other assets		142,511
Investment in New Jersey State Medical Underwriters, Inc.		28,971
		$10,114,698
Liabilities and Fund Balance		
Accounts payable and accrued expenses		$ 401,802
Assessments collected for AMA		26,400
		428,202
Loan payable to Medical Inter-Insurance Exchange of New Jersey		2,650,153
Mortgage payable		1,291,733
Deferred revenue from member assessments		2,158,100
Deferred revenue—public relations assessments		159,443
Deferred revenue—other		243,951
Fund Balance		3,183,116
		$10,114,698

Statement of Revenue and Expenses
9 Months Ended February 28, 1991
(Unaudited)

Revenue		
Membership dues		$1,822,775
Publication sales and advertising income		228,414
Amortization of Physicians' Health Program		195,984
Amortization of public relations assessment		59,300
Investment income		169,032
Royalty income		208,977
Rental income		425,024
Annual Meeting		37,084
Membership Directory sales		82,379
Other income		18,104
	Total Revenue	3,247,073
Expenses		
Conferences and meetings		450,454
Member services		728,891
		1,179,345
General and administrative		1,524,873
Interest		271,179
Depreciation		124,423
	Total Expenses	3,099,820
Excess of revenue over expenses before federal income tax		$ 147,253
Provision for federal income tax		(75,000)
		72,253
Equity in income (loss) of unconsolidated subsidiary		(206)
Excess of revenue over expenses		72,047
Fund balance at June 1, 1990		3,111,070
Fund balance at February 28, 1991		$3,183,117

[redacted]

The Reference Committee recommended that the report be filed.
HOUSE ACTION: Adopted. The report was filed.

COMMITTEE ON FINANCE AND BUDGET

Matis A. Fermaglich, MD
(Reference Committee "B")

The Committee on Finance and Budget met on Wednesday, March 20, 1991, for the purpose of reviewing the proposed budget for the 1991-1992 fiscal year.

The proposed budget and the following recommendations were approved by the Board of Trustees on April 7, 1991, and were submitted to the House of Delegates for approval:

1. That the budget for the fiscal year beginning June 1, 1991, and ending May 31, 1992, in the amount of $4,264,000 with $2,546,000 to be raised through member assessments be adopted.
2. That the 1992 assessment be set at $350 per regular dues-paying member. (No change from prior year.)
3. That the 1992 assessment be set at $60 per member for affiliate members (no longer practicing in New Jersey). (No change from prior year.)
4. That the 1992 assessment for associate members (interns-residents nonlicensed in New Jersey) and licensed residents, provided the individual is in a residency program entered upon within a reasonable time after his graduation from medical school, be set at $25. (No change from prior year.)
5. That the 1992 assessment be set at $10 per student for medical students. (No change from prior year.)

[redacted]

The Reference Committee recommended the approval of recommendations 1 through 5.

HOUSE ACTION: Adopted. The recommendations were approved.

Statement of Revenue and Expenses
Proposed Budget
Fiscal Year Ending May 31, 1992

Revenue (other than member assessments)		
Publication sales and advertising income		$ 222,000
Amortization of Physicians' Health Program		284,000
Amortization of public relations assessment		100,000
Investment income		125,000
Royalty income		270,000
Rental income		632,000
Annual Meeting		15,000
Membership Directory sales		60,000
Other income		10,000
	Total Revenue	$1,718,000
Expenses		
Conferences and meetings		444,000
Member services		685,000
Publications		320,000
	Total Program Expenses	$1,449,000
General and administrative		2,279,000
Interest		361,000
Depreciation		175,000
	Total Expenses	$4,264,000
Amount of expenses over revenue to be raised thru member assessments (including *NEW JERSEY MEDICINE* subscriptions and Annual Meeting assessments)		$2,546,000

Revenue from Member Assessments
Fiscal Year Ending May 31, 1992

$350 x 7,300 members	$2,555,000

Medical Society of New Jersey
Proposed Budget
Fiscal Year Ending May, 31, 1992

	Approved Budget 1990/91	Estimate Budget 5/31/91	Proposed Budget 1991/92
Compensation			
Salaries	$1,150,000	$1,146,000	$1,230,000
Pension Plan	115,000	114,000	125,000
	1,265,000	1,260,000	1,355,000
Professional Fees			
Audit	23,000	25,000	24,000
Legal	100,000	100,000	110,000
Actuarial	4,000	4,000	4,000
Special Consultants	8,000	16,000	10,000
	135,000	145,000	148,000
Councils and Committees			
Public Relations	260,000	260,000	273,000
Public Relations—Special Assessment	216,000	116,000	100,000
Legislation	88,000	88,000	88,000
President and Presidential Officers	75,000	71,000	75,000
AMA Delegates	88,000	135,000	90,000
MSNJ Auxiliary	30,000	30,000	30,000
Medical Education	43,000	40,000	30,000
Board of Trustees	35,000	48,000	35,000
Judicial Council	1,000	1,000	1,000
Reimbursement of Reps. to Mtgs.	3,000	2,000	2,000
Other Councils and Committees	45,000	35,000	40,000
Medical Student Association	10,000	12,000	10,000
Grant Allocation—MIIENJ	(330,000)	(330,000)	(330,000)
	564,000	508,000	444,000
Member Services			
Physicians' Health Program	387,000	363,000	408,000
Annual Meeting	150,000	135,000	140,000
Professional Liability	50,000	70,000	90,000
Membership Directory	57,000	55,000	47,000
	644,000	623,000	685,000
Publication			
NEW JERSEY MEDICINE	326,000	313,000	320,000
General Administrative & Operating Expenses			
Building operations (including depreciation)	713,000	766,000	728,000
Insurance	197,000	193,000	203,000
Payroll taxes	90,000	90,000	95,000
Other general office cost	367,000	279,000	286,000
	1,367,000	1,328,000	1,312,000
Total	$4,301,000	$4,177,000	$4,264,000

The Reference Committee recommended that the report be filed.
HOUSE ACTION: Adopted. The report was filed.

COUNCIL ON MENTAL HEALTH

Thomas R. Houseknecht, MD
(Reference Committee "B")

The Council on Mental Health held its reorganizational meeting on October 10, 1990. Activity this year covered the following areas:

1. Legislative Review. The Council reviewed five bills: three bills dealing with psychiatric patients' rights in screening centers and short-term care facilities, one bill dealing with the isolation of HIV-positive patients in state psychiatric hospitals, and one bill dealing with triplicate prescription forms for class III pharmaceuticals.

A. A-948—Otlowski; S-2384—Paterniti; and S-2369—DiFrancesco all guarantee the rights of psychiatric patients in screening centers and short-term care facilities. The Council found A-948 and S-2369 had troublesome features, making implementation difficult. The Council found S-2384 gave the physician more leeway and supported this bill, in lieu of the other two bills. B. A-732—J. Smith requires isolation of patients who test positive for HIV or who are diagnosed as having AIDS or AIDS-related complex in state psychiatric hospitals. In November 1989, the Council opposed bill A-4453—Smith, with a similar requirement. The Council reconsidered its previous position at its October 10, 1990, meeting, reversed itself, and supported bill A-732—J. Smith. In addition, the Council recommended legislation be considered to have continued mandatory testing of HIV-negative patients in state hospitals at appropriate intervals until it no longer is deemed medically necessary. It is further recommended that there be mandatory HIV testing for employees in state psychiatric hospitals as well. The Council recognizes the economic and possible legal impact of mandatory testing, but considers it of such medical importance to support such action. C. A-3359, doctors to write prescription class II pharmaceuticals in triplicate, was reviewed. A recommendation was made to the Council on Legislation to oppose this bill.

2. Governor's Advisory Council. "A Ten-Year Plan for New Jersey's Mental Health System" was reviewed at the October 10, 1990, and January 23, 1991, Council meetings, with recommendation to oppose features of the Plan. The Plan addresses three major components of care: local mental health authorities; a full range of mental health services in every community; and elimination of public psychiatric hospitals. The Council will review the Plan's problems with members of the Governor's Advisory Council. One proposal by the Council on Mental Health is the establishment of demonstration community programs in a few areas of the state before attempting implementation in the entire state.

3. Resolution To Provide Medical Assistance To VA and Civilian Hospitals Caring for Military Casualties and Military Family Stress of the Persian Gulf War. The Council meeting of January 23, 1991, occurred during the second week of the Persian Gulf war and feeling ran high among Council members to express recognition of the need for medical assistance and willingness for civilian physicians to help in dealing with both military casualties and military family stress of the war. The resolution sent to the Board calls for recognition of need for medical backup assistance to military systems, many depleted by reserve call ups, to have membership be aware of family stress seen in their practices, to diagnose and treat such stress, and to make appropriate referral for medical consultation and treatment. The Council will coordinate efforts with the NJ District Branch and the APA.

4. Status of the Department of Defense Plans To Train Psychologists To Prescribe Psychiatric Medications. The Department's plan to train psychologists to prescribe psychiatric medications appears stalled temporarily. Budgetary crises and the Persian Gulf war have made its implementation difficult, as has nearly 800 letters and testimony to Congress urging caution in its implementation. Criteria for evaluating the adequacy of such a training program and its location at the Uniformed Services Training Center at Bethesda Naval Hospital, or Walter Reed Army Hospital, have not been resolved. Two psychologists began 16 weeks of didatic training at Fort Sam Houston, Texas, completed in December 1990. They were transferred to Walter Reed Army Hospital for clinical training. One psychologist withdrew. The other psychologist at Walter Reed Army Hospital is awaiting resolution on the criteria and location problems.

[redacted]

The Reference Committee recommended that the report be filed.

HOUSE ACTION: Adopted. The report was filed.

COUNCIL ON PUBLIC HEALTH

Charles J. Moloney, MD
(Reference Committee "B")

The Council on Public Health met on June 13, 1990, and discussed the following topics:

A. Solid Waste Disposal. The Committee on Environmental Health discussed solid waste disposal and submitted a recommendation to the Council on Public Health. The Board of Trustees approved this recommendation on July 15, 1990:

> That the Board of Trustees advise the Department of Environmental Protection that the Society urges adoption of the following:
>
> (a) That a more comprehensive waste program be formulated, including a reduction of materials through composting and other forms of segregation and recycling.
>
> (b) That the necessity of recycling be reduced by lowering the amounts of available packaging and other disposable materials by regulations and/or incentives.
>
> (c) That the use of composting be maximized to reduce the volume of material that must be otherwise disposed of.

B. Disposal of Low-Level Radioactive Waste. The Committee on Environmental Health reviewed the Federal Low-Level Radioactive Waste Policy Act of 1980, requiring each state to assume responsibility of specific low-level radioactive waste generated within its borders. After review, the Committee submitted the following recommendation to the Council on Public Health:

> (a) That the Department of Environmental Protection be advised that the Medical Society of New Jersey recognizes the importance of low-level radioactive waste facility siting and approves the concept of concern for both the environmental facility and for the people of the surrounding community.
>
> (b) That the Department of Environmental Protection be urged to involve the MSNJ membership in the process.

C. Other Items. The Committee on Environmental Health will review medical waste disposal companies listed by the New Jersey State Department of Environmental Protection, so that the Committee on Membership Services can make an endorsement. The Committee is acting on Resolution #15, 1989 House of Delegates.

[redacted]

The Reference Committee recommended that the report be filed.
HOUSE ACTION: Adopted. The report was filed.

COMMITTEE ON ANNUAL MEETING

Donald J. Holtzman, MD
(Reference Committee "B")

The proposed sites for the 1991 Annual Meeting were reviewed. The Committee decided to hold the meeting at the Trump Taj Mahal Casino/Resort in Atlantic City. It also was recommended that the Committee try to plan two or three years down the line for proposed meeting sites and dates of the Annual Meeting.

The Board of Trustees of the Medical Society of New Jersey approved the Committee on Annual Meeting's recommendation that the 1991 Annual Meeting be held at the Trump Taj Mahal Casino/Resort in Atlantic City. The Merv Griffin's Resorts Casino Hotel will participate with the headquarters hotel (Trump Taj Mahal) for the 1991 Annual Meeting.

The educational programs and speakers will be determined by Doctors Douglas M. Costabile (MSNJ president) and Joseph A. Riggs (MSNJ president-elect). The cooperation of the Academy of Medicine of New Jersey is assured.

In regard to the format of the meeting, the Board of Trustees' meeting will be held on Saturday, April 27, 1991. Registration will open Sunday, April 28, 1991, and the first educational program will be at 10:00 A.M. on that day. The exhibits will open at 11:30 A.M., and the House of Delegates will convene at 1:30 P.M. followed by the reference committees at 3:30 P.M.

On Monday, April 29, 1991, elections will be held at 9:00 A.M. and the Golden Merit Award Ceremony will be held at 12:00 NOON. The two remaining reference committees will be meet at 2:30 P.M. and at 5:00 P.M. JEMPAC will have its political forum.

On Tuesday, April 30, 1991, the House of Delegates will convene at 9:00 A.M. and again at 1:30 P.M. The exhibits will close at 2:00 P.M. and the Inaugural Reception and Dinner Dance honoring Incoming President Joseph A. Riggs, MD, will be at 7:00 P.M.

On Wednesday, May 1, 1991, there will be an educational program at 8:30 A.M. and the Board of Trustees will meet at 1:00 P.M.

The Society is arranging to have a meeting-hospitality area available for the delegates and the county society executives when Society functions are not scheduled. Arrangements are being made to have the area available Sunday and Monday, April 28-29, 1991, from 6:30 P.M. to 10:30 P.M.

[redacted]

Based on comments received, the Reference Committee urged the Committee on Annual Meeting to seek nonsmoking facilities at future meeting sites.

The Reference Committee recommended that the report be filed.

HOUSE ACTION: Adopted. The report was filed.

NOMINATIONS FOR EMERITUS MEMBERSHIP

(Reference Committee "B")

The following nominations for election to emeritus membership at the 1991 Annual Meeting have been received from component societies. Conforming to the provisions of the Bylaws, Chapter I—Membership Section 1—Composition (d), all nominees have been members in good standing of a component society and who by reason of age or infirmity have retired from the active practice of medicine, or members of this Society who have been disabled by reason of military service.

Atlantic County

Irwin S. Budnick, MD, Margate City; age 65
Robert E. Sinderbrand, MD, Egg Harbor; age 75

Bergen County

Nadia M. Amato, MD, Old Tappan; age 60
Hugh Auchincloss, MD, HoHoKus; age 60
~~Richard B. Berlin, Sr, MD, Teaneck; age 73;~~ deceased, April 1, 1991
Bruce M. Burtan, MD, Saddle River; age 64
Yu Shang Chang, MD, Tenafly; age 69
Solomon Chazan, MD, Fair Lawn; age 66
Walter M. Chemris, MD, Ridgewood; age 69
Kathleen V. Cuddihy, MD, Cresskill; age 70
J. Lawrence Evans, Jr, MD, Englewood; age 79
John F. Friery, MD, Bergenfield; age 73
H. Richard Hoff, MD, Old Tappan; age 61
John Kwittken, MD, Fort Lee; age 61
Walter Lichtenberg, MD, Westwood; age 83
Heinz I. Lippmann, MD, Teaneck; age 83
Robert J. Oehrig, MD, Glen Rock; age 70
Dermot B. O'Herlihy, MD, Ridgewood; age 67
Paul A. Prior, MD, Saddle River; age 66
Louis M. Sod, MD, Fort Lee; age 65
Nikolaus Zarudsky, MD, Ridgewood; age 68

Burlington County

Perry S. MacNeal, MD, Moorestown; age 78
John G. Rogers, MD, Ponte Verdra Beach, FL (formerly Riverton); age 66
Joseph Ziegler, MD, Burlington; age 74

Camden County

Edward J. Brill, MD, Cinnaminson; age 61
Elizabeth J. Esoda, MD, Haddon Heights; age 65
Vincent P. Mahoney, MD, Haddonfield; age 77
William V. McDonnell, MD, Haddonfield; age 69
Francis G. Meidt, MD, Merchantville; age 67
Lindsay L. Pratt, MD, Cherry Hill; age 65
Luigi A. Principato, MD, Voorhees; age 71

Cumberland County

James E.D. Gardam, MD, Vineland; age 70

Essex County

Frederick N. Bailey, MD, Montclair; age 69
Daniel N. Burbank, MD, Avon-by-the-Sea; age 70
Stephen Dmytriw, MD, Bloomfield; age 76

Mervin E. Fischman, MD, Boynton Beach, FL (formerly Livingston); age 71
Norman Sacharow, MD, Ft. Lauderdale, FL (formerly Elizabeth); age 67
Myron J. Shapiro, MD, Newark; age 70
Calvin C. Smith, MD, Newark; age 67
Stephen J. Sopkia, MD, Montclair; age 66
John F. Vining, MD, Bloomfield; age 74
Frank Y. Watson, MD, Glen Ridge; age 65
George G. Wilson, MD, West Orange; age 62

Hudson County

Bernard M. Altschuler, MD, Bayonne; age 70
Urban R. Bigliani, MD, North Bergen; age 83
Joseph A. Guerra, MD, Glen Ridge; age 70
Benjamin J. Macchia, MD, Jersey City; age 87

Mercer County

Keith G. Battin, MD, Hopewell; age 68
Albert Davne, MD, Princeton; age 70
Joseph A. deBlois, MD, Trenton; age 69
Dara B. Dubash, MD, Yardley, PA (formerly Trenton); age 71
Kenneth Kaminker, MD, Trenton; age 58
Michael J. Larkin, MD, Yardley, PA (formerly Trenton); age 73.
George M. Malkiewicz, MD, Trenton; age 69
Arthur H. Randelman, MD, Trenton; age 70
John A. Sakson, III, MD, Yardley, PA (formerly Trenton); age 69
Frank P. Santucci, MD, Trenton; age 67
Paul T. Williams, MD, Lawrenceville; age 72
Levon D. Yazujian, MD, Trenton; age 72

Middlesex County

William A. Allgair, MD, South River; age 69
Joseph C. Borrus, MD, Edison; age 75
Basil Campean, MD, Metuchen; age 71
Francis G. Casey, Jr, MD, North Plainfield; age 79
Joseph T. Harris, MD, Perth Amboy; age 61
Ludwig R. Paglia, MD, Woodbridge; age 64

Monmouth County

Joseph R. Ackerman, MD, Asbury Park; age 69
Evelio R. Bofill, MD, West Long Branch; age 68
Julio T. Noguera, MD, Wall; age 65
Michael Piacentini, MD, Brielle; age 67
Joseph Woolwich, MD, Long Branch; age 66

Morris County

Lawrence P. Benza, MD, Wharton; age 70
Bayard N. Coggeshall, MD, Brookside; age 75
John J. Dudasik, MD, Rockaway; age 70
Veronica V. Gal, MD, Convent Station; age 66
Patricia M. Gibney, MD, Morristown; age 69
Salvatore Giordano, MD, Morristown; age 80
~~James M. McDonough, MD, Morris Plains; age 57;~~ deceased, May 5, 1991
Harry R.H. Nicholas, III, MD, Morristown; age 67

Ocean County

Clifford A. Baldwin, Jr, MD, Manahawkin; age 69
John P. Kengeter, MD, Toms River; age 70

Passaic County

Sidney Cohn, MD, Verona; age 68
Robert M. D'Andrea, MD, Wayne; age 66
Louis S. Saco, MD, Franklin Lakes; age 78
Boris Schwartz, MD, Wayne; age 69

Sussex County

Douglas A. Hammett, MD, Andover; age 58
John C. Lucas, Jr, MD, Newton; age 67

Union County

David Brailovsky, MD, Mountainside; age 66
Milton D. Fox, MD, Mountainside; age 67
Roland Johnkins, MD, North Brunswick; age 66
Benjamin H. Josephson, MD, Basking Ridge; age 66
Howard Lehr, MD, Gillette; age 62
Sidney G. Piness, MD, Plainfield; age 71
John J. Sprowls, MD, Rahway; age 67

The Reference Committee recommended that the nominations be approved.
HOUSE ACTION: Adopted. The nominations were approved.

SUPPLEMENTAL REPORT #1: NOMINATIONS FOR EMERITUS MEMBERSHIP

(Reference Committee "B")

Additional nominations for election to emeritus membership have been received:

Bergen County

Edward J. Davis, MD, Tenafly; age 67
Nelson C. Walker, MD, Hackensack; age 78

Camden County

Edwin A. Gleason, MD, Cherry Hill; age 71

Essex County

Francis T. Christoph, MD, Union; age 78
Frederick G. Coester, MD, Chatham; age 62

Morris County

Dean C. Shore, MD, Morristown; age 63

Union County

Eugene C. Hohenstein, MD, Westfield; age 67

The Reference Committee recommended that the nominations be approved.
HOUSE ACTION: Adopted. The nominations were approved.

SUPPLEMENTAL REPORT #2:
NOMINATIONS FOR EMERITUS MEMBERSHIP

(Reference Committee "B")

Additional nominations for election to emeritus membership have been received:

Morris County

Rudolf Schwaeble, MD, Deerfield Beach, FL; age 67

Union County

W. Lamar Bomar, MD, Plainfield; age 71
Theodore Chenkin, MD, Carteret; age 70

The Reference Committee recommended that the nominations be approved.
HOUSE ACTION: Adopted. The nominations were approved.

SUPPLEMENTAL REPORT #3:
NOMINATIONS FOR EMERITUS MEMBERSHIP

(Reference Committee "B")

An additional nomination for election to emeritus membership has been received:

Essex County

David Miller, MD, Basking Ridge; age 67

The Reference Committee recommended that the nomination be approved.
HOUSE ACTION: Adopted. The nomination was approved.

RESOLUTION #2

Introduced by: Middlesex County Medical Society
Subject: Reinstatement of Members
Referred to: Reference Committee "B"

Whereas, due to the large number of critical political issues at both the state and federal levels that have a direct impact on the practice of medicine and our Society, every effort should be made to increase our membership in order to present a unified voice; and

Whereas, the Medical Society of New Jersey and its component county societies recently have found it difficult to increase its membership; and

Whereas, our Society presently prevents past members from rejoining without payment of delinquent dues for one year unless a hiatus of 24 months has passed; now therefore be it

Resolved, that if a hiatus in dues payment to MSNJ of greater than 12 months from June 1 exists, there shall not be a delinquency assessment payable to MSNJ.

[redacted]

Since nonpayment of dues is only one facet of the drop in membership, the Reference Committee felt that Resolution #2 does not fully address the problem.

The Reference Committee recommended that Resolution #2 be referred to the Ad Hoc Committee on Membership for rewording and appropriate action.

HOUSE ACTION: Not adopted. Resolution #2 was referred to the Board of Trustees.

RESOLUTION #4

Introduced by: Union County Medical Society
Subject: HIV Testing for Hospital Patients
Referred to: Reference Committee "B"

Whereas, the Centers for Disease Control reported on May 2, 1990, an incidence of 25 percent HIV positive tests at one hospital in the New Jersey-New York area; and

Whereas, New Jersey has one of the highest rates of HIV positivity in the nation; and

Whereas, knowledge of patients' HIV statuses is important in further diagnosis and treatment of patients; and

Whereas, knowlege of HIV positivity is helpful in protecting hospital personnel; now therefore be it

~~**Resolved,** that MSNJ seek legislation to permit HIV testing to be performed on any hospitalized patient with or without the patient's specific consent. It is understood that any patient who tests positive on both the ELISA and Western blot tests will be so informed and will receive counseling.~~

Resolved, that MSNJ support universal HIV testing to be performed on all hospitalized patients; and be it further

Resolved, that MSNJ support periodic universal HIV testing of all health care personnel, including physicians; and be it further

Resolved, that any individual who tests positive on both the ELISA and Western blot tests be so informed and receive counseling; and be it further

Resolved, that any HIV test results be treated with the utmost confidentiality.

[redacted]

The Reference Committee objected to the Resolution's emphasis on the enactment of legislation and preferred the adoption of policies on HIV testing.

The Reference Committee recommended that the resolved be deleted and the addition of a Substitute Resolution with four new resolveds.

The Reference Committee recommended that Substitute Resolution #4 be adopted.

HOUSE ACTION: Adopted. Substitute Resolution #4 was adopted.

RESOLUTION #8

Introduced by: Essex County Medical Society
Subject: Over-the-Counter Hypodermic Needles
Referred to: Reference Committee "B"

Whereas, the New Jersey law requiring a physician's prescription to obtain hypodermic needles has been in effect for the last 30 years; and

Whereas, many new HIV infections result from the reuse and multiple serial usage of hypodermic needles by addicts; and

Whereas, the use of needles by addicts is the largest AIDS spreading problem in New Jersey; and

Whereas, AIDS education has been aimed at addicts to encourage the use of sterile needles; and

Whereas, drug addicts are not likely to visit a physician's office prior to holding a session where consecutive usage of one needle often is routine; and

Whereas, the use of taxpayer money to provide a needle dispensing program is not expedient; and

Whereas, a million needles on the open market are far less costly than one AIDS case; now therefore be it

Resolved, that the Medical Society of New Jersey seek the repeal of the statute that makes a physician's prescription necessary to obtain hypodermic needles so they may be purchased at pharmacies to reduce the high incidence of new AIDS cases; and be it further

Resolved, that if the law is changed, the Medical Society of New Jersey publicize the availability of over-the-counter hypodermic needles so drug addicts may purchase new sterile needles.

[redacted]

The Reference Committee recommended that Resolution #8 be rejected.

HOUSE ACTION: Adopted. Resolution #8 was rejected.

RESOLUTION #10

Introduced by: Essex County Medical Society
Subject: Bicycle Helmets and Safety
Referred to: Reference Committee "B"

Whereas, the New Jersey State Safety Council reported 18 deaths of bicyclists in 1989 with 9 deaths occurring in children under the age of 16, and the Insurance Institute for Highway Safety reported 821 deaths to bicyclists nationwide in 1989 with half of the deaths occurring in children under the age of 16; and

Whereas, the Consumer Product Safety Commission found that over 75 percent of all cyclist deaths involve head injuries and that more than 380,000 children are injured in bicycle-related incidents each year; and

Whereas, the National Health Interview Survey found that nearly 70 percent of hospitalized cyclists are treated for head trauma; and

Whereas, the American Academy of Pediatrics, "Statement on Bicycle Helmets," and the recent American Medical Association Resolution #7 on bicycle helmets and safety ask for public support through various means for the mandatory use of safe and inexpensive bicycle helmets; now therefore be it

Resolved, that the Medical Society of New Jersey actively support bicycle helmet use and encourage physicians to educate ~~patients~~ the public about the importance of bicycle helmet use; and be it further

Resolved, that the Medical Society of New Jersey encourage the manufacture, distribution, and utilization of safe, reasonably priced bicycle helmets; and be it further

Resolved, that the Medical Society of New Jersey encourage the availability of helmets at the point of bicycle purchase; and be it further

~~**Resolved, that the Medical Society of New Jersey encourage appropriate legislation requiring bicycle safety helmets.**~~

Resolved, that the Medical Society of New Jersey support proposed legislation requiring bicycle safety helmets.

[redacted]

The Reference Committee recommended that the word "patients" in the first resolved be deleted and the words "the public" be substituted.

HOUSE ACTION: Adopted.

The Reference Committee recommended that the fourth resolved be deleted and amended as shown.

HOUSE ACTION: Adopted.

The Reference Committee recommended that Resolution #10 be adopted as amended.

HOUSE ACTION: Adopted. Resolution #10 was adopted as amended by the Reference Committee.

RESOLUTION #12

Introduced by: Essex County Medical Society
Subject: ~~Sale of Cigarettes by Pharmacies~~
Sale of Tobacco Products by Pharmacies
Referred to: Reference Committee "B"

Whereas, sound scientific evidence has established that cigarette smoking is clearly detrimental to public health by contributing substantially to the occurrence of cardiovascular and pulmonary disease and cancer, leading to unacceptable rates of morbidity; and

Whereas, the medical profession and its affiliated professions, as well as health care institutions throughout the state, have adopted policies to discourage the practice of cigarette smoking; and

Whereas, most health care institutions throughout New Jersey have forbidden the sale of cigarettes within their facilities; and

Whereas, retail pharmacies, that deal in the sale of products intended to promote health, continue to permit the sale of cigarettes to their customers, a practice incongruent with the promotion of health; now therefore be it

~~**Resolved,** that the Medical Society of New Jersey call upon the New Jersey Pharmaceutical Association and related organizations to promulgate policies and procedures encouraging retail pharmacies throughout the state to ban the sale of cigarettes on their premises.~~

Resolved, that the Medical Society of New Jersey support the New Jersey Pharmaceutical Association and related organizations in their efforts to promulgate policies and procedures encouraging retail pharmacies throughout the state to ban the sale of tobacco products from their premises.

The Reference Committee recommended that the resolved be deleted and amended as shown.

HOUSE ACTION: Adopted.

The Reference Committee recommended that Resolution #12 be adopted as amended.

HOUSE ACTION: Adopted. Resolution #12 was adopted as amended by the Reference Committee.

RESOLUTION #13

Introduced by: Essex County Medical Society
Subject: No Guest Speaker at Last Day of MSNJ House of Delegates
Referred to: Reference Committee "B"

Whereas, on the last day of the House of Delegates, the delegates consider at length, and in detail, the important reports of the reference committees; and

Whereas, all resolutions before the convention are voted on at this time; and

Whereas, all policy for the future is established at these voting sessions; and

Whereas, these sessions are sometimes delayed beyond hotel checkout because out-of-state and other speakers are scheduled prior to hearing reference committee reports; and

Whereas, a number of delegates leave before all business is conducted and the House of Delegates may not have a quorum to transact important business; and

Whereas, all speakers can be accommodated at the other sessions of the House of Delegates or given a separate forum; now therefore be it

~~**Resolved,** that no speakers, out of state or otherwise, be scheduled to address the House of Delegates at the sessions when reference committee reports are presented.~~

Resolved, that guest speakers, out of state or otherwise, routinely be scheduled to address the House of Delegates at the first and second sessions, leaving the final session for consideration of reference committee reports.

The Reference Committee recommended that the resolved be deleted and amended as shown.

HOUSE ACTION: Adopted.

The Reference Committee recommended that Resolution #13 be adopted as amended.

HOUSE ACTION: Adopted. Resolution #13 was adopted as amended by the Reference Committee.

COUNCIL ON MEDICAL SERVICES

Richard H. Sharrett, MD
(Reference Committee "C")

The Council on Medical Services held its reorganizational meeting on January 30, 1991, and addressed the following items: Resolution #5—1990 House of Delegates, Realistic Child and Scholastic Child Athletes; insurance plan for the elderly/Medicare alternative; presentation by William Schwarz, assistant director, Disability Insurance Service, New Jersey; correspondence from Union County Medical Society regarding Medallion 2000 and Prudential Insurance Company; and correspondence concerning 90-day limit for filing insurance claims. A supplemental report will be filed.

[redacted]

The Reference Committee recommended that the report be filed.
HOUSE ACTION: Adopted. The report was filed.

SUPPLEMENTAL REPORT #1: COUNCIL ON MEDICAL SERVICES

Richard H. Sharrett, MD
(Reference Committee "C")

Ad Hoc Committee on Insurance Plan for the Elderly/Medicare Alternative. A suggestion that the Society create and operate a private insurance plan for New Jersey elderly to replace Medicare Part B was referred to the Council by the Board of Trustees. This proposal was presented by Doctor Lois Copeland of Bergen County.

Doctor Copeland discussed her suggestions and efforts to replace Medicare Part B. She advised the Council that she has contacted several private insurance companies in an effort to interest them in such an insurance program.

Doctor Copeland suggested that the Medical Society of each state should set up a plan that gives physicians the governmental funds for the medical treatment of the elderly. This program could be supervised by physicians and operated as a nonprofit program. It is believed that physicians should have the right to treat patients outside of the Medicare program without either encountering any legal hazards from the federal government.

The Council members agreed that the support of the senior citizen population is very important in working toward a solution to the Medicare problem.

The consensus was that Doctor Copeland should continue gathering information. No expensive feasibility study should be recommended at this time. There are several groups currently investigating the Medicare problem.

In regard to Doctor Copeland's suggestion to create a Medicare alternative plan, the Council also agreed to explore the possibility of instituting a regional or statewide program whereby a premium is paid for coverage of all services.

The recommendation that the Board of Trustees request the AMA delegation to introduce a resolution allowing the patient and physician freedom of choice to construct an economic service delivery system outside of Medicare Part B, without penalty, has been forwarded to the Board of Trustees for their consideration. (Note: The Board did not act on the matter since it already is standing policy of the AMA.)

[redacted]

The Reference Committee recommended that Supplemental Report #1 be filed.
HOUSE ACTION: Adopted. The Supplemental Report #1 was filed.

RESOLUTION #1

Introduced by: Hudson County Medical Society
Subject: Medicare Notification of Payment
Referred to: Reference Committee "C"

Whereas, as of September 1, 1990, physicians must submit all Medicare claims, assigned or nonassigned; and

Whereas, on nonassigned claims, the physician receives no Explanation of Medicare Benefits (EOMB); and

Whereas, the physician thus has no way of knowing whether nonassigned claims have been paid to the patient; and

Whereas, patients have been known to contend that they have not received payment, and that the physician may not have submitted a claim; now therefore be it

Resolved, that the Medical Society of New Jersey request that the Medicare carrier acknowledge receipt and disposition of nonassigned claims; and be it further

~~**Resolved,** that this resolution be forwarded to the American Medical Association with the request that the Health Care Financing Administration (HCFA) mandate Part B carriers to notify physicians of the receipt of nonassigned claims.~~

Resolved, that this Resolution be forwarded to the American Medical Association with the request that the Health Care Financing Administration mandate Part B carriers to furnish both participating and nonparticipating physicians with an Explanation of Medicare Benefits (EOMB) on all claims, whether assigned or nonassigned.

[redacted]

On consultation with MSNJ's general counsel, the Reference Committee was made aware that the privacy act would not be a problem in implementing this Resolution.

The Reference Committee recommended that Resolution #1 be adopted.

HOUSE ACTION: Not adopted. Resolution #1 was adopted as amended by the House of Delegates.

RESOLUTION #11

Introduced by: Essex County Medical Society
Subject: Physician Advisory Committees to Insurance Companies
Referred to: Reference Committee "C"

Whereas, the New Jersey State Department of Health and the Governor's Commission on Health Care Costs clearly indicate a need for greater state involvement in health care treatment and reimbursement; and

Whereas, there currently is minimal physician input on both a state and local level regarding health care treatment and reimbursement by insurance companies; now therefore be it

Resolved, that the House of Delegates urge each county medical society, along with the hospital staffs within that county, to form a physician advisory committee to consult with insurance companies on issues regarding the medical needs of the community; and be it further

Resolved, that the Medical Society of New Jersey and representatives of county advisory committees form a state physician advisory committee to consult with the New Jersey State Department of Health and the New Jersey State Department of Insurance on issues regarding the medical needs of the state.

[redacted]

The Reference Committee recommended that Resolution #11 be adopted.

HOUSE ACTION: Adopted. Resolution #11 was adopted.

RESOLUTION #16

Introduced by: Bergen County Medical Society
Subject: Fee Negotiations and Insurance Complaints
Referred to: Reference Committee "C"

Whereas, physicians are being harassed by insurance companies seeking additional reports and/or copies of records to substantiate physicians' fees; and

Whereas, insurance companies delay payments of fees and make numerous time-consuming requests for information; and

Whereas, insurance companies have contracted with management corporations for the purpose of negotiations of fees and have not previously paid the approved usual and customary range of fee; and

Whereas, insurance reviews and determinations of care are being done by nurse coordinators and not by physicians of comparable specialties; and

Whereas, patients have the right to complain through the New Jersey State Department of Insurance; now therefore be it

Resolved, that the Medical Society of New Jersey urge the commissioner of insurance to allow physicians the right to originate complaints directly to the New Jersey State Department of Insurance; and be it further

Resolved, that the Medical Society of New Jersey notify the insurance industry that fee disputes should be considered for arbitration and the uncontested amount paid promptly, with the negotiating conference quickly scheduled and the final allowed balance paid within 15 days.

The Reference Committee noted that the second resolved is current MSNJ policy.
The Reference Committee recommended that Resolution #16 be adopted.
HOUSE ACTION: Adopted. Resolution #16 was adopted.

RESOLUTION #17

Introduced by: Passaic County Medical Society
Subject: Reimbursement of Nonassigned Claims
Referred to: Reference Committee "C"

Whereas, most patients expect insurance companies to pay the physician directly upon submission of claims; and

Whereas, payments sent directly to patients frequently are not remitted to the physician, forcing physicians to initiate legal action to collect the money owed them; now therefore be it

~~**Resolved,** that the Medical Society of New Jersey actively sponsor and seek enactment of legislation or regulations that would require all insurance companies selling health coverage policies in New Jersey to issue assigned reimbursement checks payable to the physician.~~

Resolved, that the Medical Society of New Jersey actively sponsor and seek enactment of legislation or regulations that would require all insurance companies selling health coverage policies in New Jersey to honor the patient's assignment of medical expense benefits to the physician whenever duly executed.

The Reference Committee recommended that Resolution #17 be adopted.
HOUSE ACTION: Not adopted. Resolution #17 was adopted as amended by the House of Delegates.

RESOLUTION #18

Introduced by: New Jersey Society of Internal Medicine
Subject: Home Health Care Services—Medicare
Referred to: Reference Committee "C"

Whereas, the need for home health care services for Medicare beneficiaries continues to increase; and

Whereas, physicians are spending increasing amounts of time and expertise on case management for home health care services; and

Whereas, present Medicare policy does not allow reimbursement of physicians for home health care case management; now therefore be it

Resolved, that the Medical Society of New Jersey, through its AMA Delegation, encourage the AMA, as a priority item, to vigorously petition Congress and the Health Care Financing Administration to authorize adequate reimbursement for home health care case management by physicians.

The Reference Committee recommended that Resolution #18 be adopted.

HOUSE ACTION: Adopted. Resolution #18 was adopted.

COUNCIL ON PUBLIC RELATIONS

Andrew Coronato, MD
(Reference Committee "D")

The Council on Public Relations studied a number of projects in conjunction with the suggestions offered by the House of Delegates, the Board of Trustees, the general membership, and individual contributions made by members of the Council on Public Relations, as well as legislative public relations campaign contributions from Clark Martin.

1. ***Resolutions and Recommendations–1990,*** from the House of Delegates, Board of Trustees, Council on Public Relations, membership, and executive director of the Medical Society of New Jersey.

A. *Resolution #15—Tax Deductions for Uncompensated Care.* It was the opinion of the Council on Public Relations that there is insufficient evidence to conclude that providing indigent care provides greater liability exposure than care provided to paying patients. The public could be made aware that the medical profession provided $500 million in free health care in 1989, according to the New Jersey commissioner of health. Society materials directed to the Legislature and the public have emphasized that fact.

B. *Resolution #16—No To National Health Insurance.* The Council on Public Relations will study this matter further.

C. *Resolution #24E—Representation on Governor's Commission on Health Care Costs (Resolved #3).* The Society lodged numerous and vigorous protests with the governor that proved fruitless. The Legislature has been made aware of this deficiency.

D. The Council reviewed and discussed programming of the Medical Society of New Jersey's public relations activities for the 1990 yearly schedule. The major focus of the year's public relations campaign was educating the public about the causes of the rising costs of health care in the state of New Jersey. The Council developed and implemented the following media releases: "Why Are Your Health Care Costs Going Up?"; "You're Paying What the Government Won't"; "DRGs Are Costing You Money"; "There Are Many Reasons, But Medicare Reimbursement to Physicians Isn't One of Them"; "We've Told You Why. Now Let's Look at What We Can Do About It"; and "You Can't Get 1990s Medicare for 1960s Prices." Other media releases included the following: "Not the Exercise Type?"; "Can't Quit?"; "Should You Get a Mammogram?"; "Can't Say No?"; and "Thanks To Her Physician, She's Getting a Break on Medical Care." The Council on Public Relations provided posters on the Senior Medical Courtesy Program to all Medical Society of New Jersey members for display in their offices. The advertisement also was sent to all senior citizen organizations in New Jersey and all New Jersey hospitals. Another media release, "Increase on Health Insurance Premiums," was distributed throughout the state. Material is being developed to demonstrate that physician fees and health insurance costs are not necessarily related.

There were two mailings to the New Jersey Senate and Assembly: *Health Access New Jersey.* Based on a national plan developed by the AMA, *Health Access New Jersey* suggests a number of solutions that will be useful to determine how to reshape New Jersey's health care delivery system. It was delivered to the governor in August 1990 and to the Legislature in the early fall. The second mailing was on mandatory Medicare assignment. The Medical Society of New Jersey informed the legislators on the reasons why physicians are opposed to mandatory Medicare assignment in the state of New Jersey. They also received a copy of our Senior Medical Courtesy Program brochure. The membership was advised to express their feelings to their legislators. The Medical Society of New Jersey's public relations efforts are directed to present an acceptable image of the New Jersey physicians who are attempting to deliver quality health care to their patients under increasingly difficult conditions and to encourage the public to make their concerns known to their legislative representatives.

2. ***Public Relation Activities—Continuing Projects.***

a. Publication and distribution of the Membership Newsletter as part of *NEW JERSEY MEDICINE,* the journal of the Medical Society of New Jersey.

b. Monthly public health/public relations releases in the media, primarily newspapers and magazines, e.g. *Time, Newsweek.*

c. Thirty-second public service television releases on proper health care.

d. Preparation and distribution of special news releases and publicity as required in

furtherance of the Society's interest and activities including: Annual Meeting, selected official programs, and special activities.

e. The Golden Merit Award Ceremony for Medical Society of New Jersey senior physicians who have held the degree of doctor of medicine for 50 years, to receive formal recognition from their peers for devotion to their profession and the patients they have faithfully served.

f. Support of orientation programs for new members by component societies.

g. Placement services in *NEW JERSEY MEDICINE.*

h. Participation in medical television programs of informational value to the public: such as "Breast Cancer"; "Mission From The Heart"; "Why Your Health Care Costs Are Going Up"; and "Uncompensated Care" on Channel 9-13-16 (cable) and New Jersey Network. We also used commercial stations in New York and Philadelphia, with doctors from our Society as speakers, plus political action program support, such as Caucus New Jersey, e.g. the Todd Whitman—Bradley debate, and a focused interview with Governor James Florio.

i. Newspaper releases, e.g. on health topics, including a major communications campaign heightening awareness of the rising cost of health care in major newspapers in New Jersey.

j. Public service television announcements aired out of New York and Philadelphia commercial stations and New Jersey Network Public Broadcasting television, using 30-second television tapes.

3. ***Special Programming.*** The following were special programming items: participation on Governor's Committee on Child Abuse; support of Eye Health Screening Program; support of legislative activities by Clark Martin; special press conference on uncompensated care—Doctor Coronato; development of annual public relations brochure for membership information; and AMA Federation Network News public service releases including, "Why Are Your Health Care Costs Going Up?" as a clear demonstration of the MSNJ's public concern and physician advocacy. They want to share it with the Federation as an opportune way to retain membership and to get nonmembers' attention.

[redacted]

The Reference Committee recommended that the report be filed.

HOUSE ACTION: Adopted. The report was filed.

COUNCIL ON LEGISLATION

Irving P. Ratner, MD
(Reference Committee "D")

This report presents a summary of the ultimate status of legislative measures of the first half of the 204th Legislature. The Council's operations, together with a cumulative report of MSNJ's official positions on current legislation, are reflected regularly in the official bulletins dispatched to state legislative keymen and to component societies, and in items published in the Membership Newsletter in *NEW JERSEY MEDICINE*, the journal of the Medical Society of New Jersey.

The Council on Legislation continues to invite an official representative from each specialty society to all Council meetings. A notice announcing the date of each of the Council's meetings also is sent to all MSNJ official intermediaries with New Jersey specialty societies.

The Council urges more representatives attend its meetings so that it may have the benefit of the timely thinking of specialty societies concerning proposed legislation affecting the specialty fields.

The Council also invites the chairman or representatives of each council and standing committee to attend the legislative meetings. Recent bylaw amendments make it possible for one Auxiliary member, one resident member, and one student member appointed by the president, to serve on the administrative councils and committees for a one-year term to be full voting members of the representative council and committees.

Of the bills reported to the House from the First Session of the 204th Legislature, the following were signed into law:

A-546—Impreveduto—Physical Modalities. Provides that physicians, podiatrists, and chiropractors may not use unlicensed aides to administer ultraviolet (B and C bands) and electromagnetic rays. **Approved.**

A-346—Deverin—Respiratory Therapists. Creates a Board to license and regulate respiratory therapists. Services are to be provided under the direction or supervision of a physician. **Active Opposition.**

The following is a list of bills of the 1990-1991 Legislature that were reviewed after the meeting of the 1990 House of Delegates:

Senate/Assembly
(Active)

S-2546—Lynch—Contact Lens Dispensing. Provides for the regulation and certification of contact lens dispensers by the Board of Ophthalmic Dispensers and Technicians. **Disapproved, with Active Opposition if the bill moves,** the fitting of contact lenses exposes patients to certain eye injuries. The task, therefore, requires the care, skills, and experience of optometrists and physicians.

S-2583—Feldman—Social Workers. Licenses the practice of social workers and includes the diagnosis and treatment of mental and emotional disorders and the use of psychotherapy. **Active Opposition,** there has been no demonstrative need for licensure of this occupation as a separate and independent profession.

S-2607—Codey—Licensure/Burden of Proof. Raises the standard of proof in medical and podiatry disciplinary proceedings to "clear and convincing." **Active Support.**

S-2637—Dalton—Structured Verdicts. Provides for structured verdicts when future damages exceed $250,000. **Active Support.**

S-2648—Girgenti—County Ombudsman. Creates a county ombudsman system to serve as an investigational and enforcement arm of the State Office of the Ombudsman for the Institutionalized Elderly. Each county would decide whether to participate. The state would reimburse one-half the operating expenses. **Active Opposition,** the current state office of the ombudsman produces an extensive, counterproductive, and expensive overlapping of the New Jersey State Department of Health, the State Board of Medical Examiners, and the Office of the Public Advocate. Creation of county units would generate fiscal and operational chaos.

S-2663—VanWagner—Nurse Midwives/Prescriptions. Permits nurse midwives to prescribe drugs as delineated in standing orders and practice protocols developed with a collaborative physician. The nurse must receive the approval of the State Board of Medical Examiners to participate in prescribing activity. **Active Opposition,** nurses are not qualified to make a medical diagnosis nor to prescribe therapeutic medications.

S-2704—Paterniti—Orthotists and Prosthetists. Provides for the licensing of orthotists and prosthetists by the Division of Consumer Affairs. A nine-member advisory committee would assist the director. Two of the

nine members would be physicians. **Active Opposition,** there has not been a demonstrated need to license this practice as a profession.

S-2751—Cardinale—Physical Therapy Assistants. Provides that a physical therapy assistant may be employed by a physician, podiatrist, or chiropractor to administer ultraviolet and electromagnetic rays, deep heating agents, diathermy, and ultrasound. **Active Support.**

S-2789—Lesniak—Respiratory Care. Provides for the licensing of respiratory therapists to function under the direction or supervision of a physician. **Active Opposition,** there is no need to separately register and license these therapists since they are functioning well under existing laws.

S-3494—Zane—Unemployment. Exempts physicians acting as independent contractors from being subject to unemployment compensation and temporary disability contributions. **Active Support.**

A-2811—Doria—Optometry. Amends the optometric act to repeal that section that prohibits optometrists from practicing medicine. **Active Opposition,** optometrists are not medical doctors and, therefore, should not be given the mandate, via legislation, to prescribe and to administer drugs.

A-3001—Doria—Optometry. Same as **A-2811** except it has a revised statement. **Active Opposition** (same as **A-2811**).

A-3331—Ford—Wrongful Death. Makes various changes in the wrongful death act including expansion of recoverable damages. **Active Opposition,** this legislation will increase professional liability costs. It also will impact on other areas of liability, i.e. automobile liability, product liability.

A-3355—Bryant—Structured Verdicts. Provides for structured verdicts when future damages exceed $250,000. **Active Support.**

A-3359—Kavanaugh—Triplicate Prescriptions. Requires that all schedule II prescriptions be written on state-issued triplicate forms. **Active Opposition,** these systems have been attempted elsewhere and are not regulatory effective nor efficient.

A-3529—Impreveduto—Health Licensing. Provides that no new category of health practitioners shall be authorized without legislative approval. **Active Support.**

A-3531—Impreveduto—Nurse Midwives. Authorizes nurse midwives who have registered with the State Board of Medical Examiners to write prescriptions consistent with protocols established by their collaborative physician. **Active Opposition,** nurses are not qualified to make medical diagnosis nor to prescribe therapeutic medications.

A-3640—Cohen—Social Work. Licenses social workers and permits them to engage in diagnosis and treatment of mental disorders and to engage in psychotherapy. **Active Opposition,** there has been no demonstrative need for licensure of this occupation as a separate and independent profession.

A-4057—Zangari—Worker's Compensation. Permits an injured employee to select the physician or chiropractor of choice if his employer provides a list of approved practitioners. **Active Opposition,** today there are many various health care delivery systems—HMOs and PPOs—that employers purchase and these systems define providers by policy. (It was recommended that MSNJ meet with New Jersey Chamber of Commerce in an effort to create proposed legislation that might lead to a more prudent and more financially responsible program of worker's compensation in the state of New Jersey.)

A-4090—Bryant—Physical Therapy Services. Provides that a physical therapist may treat a patient without physician referral. **Active Opposition,** this legislation is an incursion into the practice of medicine and would allow physical therapists to examine and to treat patients without physician direction and would expose patients to delays in diagnosis, misdiagnosis, and iatrogenic injuries.

Senate/Assembly (Monitor)

S-163—Graves—AIDS. Concerns testing of persons for AIDS arrested or convicted of certain crimes. **Approved.**

S-371—VanWagner—Home Health Care. This bill establishes an 18-month home health and community care demonstration program in the New Jersey State Department of Human Services. This program is designed to provide for the delivery of community-based home health care services by local home health and community care demonstration centers to functionally impaired persons who are at least 65 years of age or older or who are disabled pursuant to the Social Security Act. **Disapproved,** the monies to be spent on this program would be better spent on current services.

S-395—VanWagner—New Jersey Health Insurance Risk Sharing Plan. Creates New Jersey Health Insurance Risk Sharing Plan. **No Action.**

S-644—Ewing—HIV Testing of Newborns. Requires that all newborns be tested for HIV sensitivity. **Approved.**

S-804—Rice—AIDS. Requires hospitals to accept their fair share of AIDS patients. **Action Deferred,** pending further information from New Jersey Hospital Association.

S-871—Rice—AIDS. Requires persons convicted of certain drug offenses to be tested for AIDS. **Disapproved,** bill should be reworded to encompass screening all prisoners for AIDS.

S-885—Rice—Sickle Cell Anemia/Newborns. Provides for detection and treatment of sickle cell anemia in newborn babies—appropriates $375,000. **Approved.**

S-1211—Ambrosio—Advance Directives for Health Care. Establishes procedures where patients may

execute advance directives for their care if they became incapable of making their own treatment decisions. **Approved.**

S-1444—Bassano—AIDS. Establishes the New Jersey AIDS and Viral Disease Tissue Research Bank and appropriates $30,000. **Disapproved,** this bill is counterproductive and would lower a nationally recognized standard testing basis.

S-1445—Bassano—Lyme Disease. The Lyme Disease Prevention and Control Act. **Approved.**

S-1698—Dorsey—EMT. Permits certain rescue squad members to be certified as emergency medical technicians and prohibits their exclusion from instruction. **Disapproved,** this bill is counterproductive and would lower a nationally recognized standard testing basis.

S-1709—Dorsey—EMT. Permits physicians and surgeons to use emergency warning lights. **No Action.**

S-2282—Bassano—Anabolic Steroids. Classified anabolic steroids as a "schedule V" drug. **Action Deferred,** pending further clarification from the commissioner of health concerning its six-month mandate to decide the merits of including anabolic steroids in the Controlled Substance Act.

S-2358—Costa—Surrogate Contracts. Provides requirements for surrogate gestation contracts. **Disapproved,** this legislation violates public policy.

S-2421—Dalton—Worker's Compensation. Applies the concept of "delayed discovery" to the statute of limitations in worker's compensation matters. **No Action.**

S-2446—VanWagner—Caller ID Blocks. Requires the Board of Public Utilities to mandate that telephone carriers provide blocking services to holders of unpublished numbers at no extra charge. **Approved.**

S-2536—Rand—Dialysis Technicians. Permits the Board of Nursing to certify and regulate the practice of dialysis technicians. **Approved.**

S-2559—Paterniti—Organ Donor Study Commission. Provides for an organ donor study commission. Two of the members would be ex-officio. Seven members would be nominated by the New Jersey Hospital Association to the governor. **Disapproved,** unnecessary legislation—organ donor program already in effect.

S-2605—DiFrancesco—Occupational Therapy. Provides for the regulation and licensing of occupational therapists and occupational therapy assistants. **No Action.**

S-2654—Paterniti—Podiatry. Permits podiatrists to certify disability for the purpose of issuing handicapped license plates. **No Action.**

S-2691—Paterniti—Uncompensated Care. Provides for documented fact finding by hospitals before reimbursement for uncompensated care is permitted. **No Action,** same as **A-3403/Law c.88 P.L.1990.**

S-2853—McManimon—Parental Notification for Abortion. Requires parental notification before an abortion is performed on a pregnant minor or incompetent female. **Disapproved,** this legislation would interfere with the physician/patient relationship and drive young women to seek illegal abortions.

S-2854—Lipman—Consent (HIV Testing). Requires written consent to HIV sensitivity testing. **Disapproved, with Active Opposition if the bill moves,** MSNJ is opposed to mandatory HIV testing.

S-2918—McNamara—New Jersey Medical Malpractice Reinsurance Association. Exempts certain medical professionals, hospitals, and HMOs from surcharge to pay the deficit of the New Jersey Medical Malpractice Reinsurance Association and requires surcharges based on loss experience. **Conditional Approval,** pending further amendments to the bill.

S-2933—Ewing—HIV Testing Persons Charged with Crimes. Requires that persons charged with crimes shall undergo HIV testing whenever they have exchanged body fluids with law enforcement officers, victims, or others. **Approved.**

S-3034—Zane—HIV Testing (Marriage License). Requires HIV testing before issuance of a marriage license. **Action Deferred,** pending further information from MSNJ's Council on Public Health.

S-3053—Dalton—Blood Transfusion (same as **A-4082**). This bill establishes the "Blood Safety Act of 1990." The bill requires that if a blood transfusion is likely to be necessary during surgery, a physician or surgeon must inform his patient of blood transfusion options, that is autologous, designated, and homologous blood transfusions. The physician or surgeon then would note on the patient's medical record that all blood transfusion options have been explained to the patient prior to surgery. **Action Deferred,** further information is being requested from the New Jersey Society of Pathologists, the New Jersey Chapter, American College of Surgeons, and the blood banks.

A-24—Kavanaugh—Surrogate Agreements. Prohibits surrogate parenting agreements for consideration as crime of the third degree. **No Action.**

A-337—Deverin—Medicaid. Broadens the scope of Medicaid eligibility. **Approved.**

A-740—Roberts—Mobile Intensive Care Services. Appropriates $8,000,000 for the Mobile Intensive Care Services Support Act. **Action Deferred,** pending further discussion by the Committee on Emergency Medical Care.

A-785—Roma—Mammograms/Insurance Coverage. Requires health insurers to provide coverage for mammograms, pap smears, and infertility tests. **Approved.**

A-793—Roma—Boating While Intoxicated Statute. Establishes additional enforcement measures to monitor sentences imposed on drunken boaters; establishes two-day jail term for sentence violations. **Approved.**

A-971—Cohen—AIDS. Makes knowing transmittal of AIDS a third-degree crime. **Conditional Approval,** the bill is legally malconstructed since the legal and medical portions of the bill are in error.

A-1191—Cooper—Death with Dignity Act. Approved.

A-1341—Bryant—Right To Die Act. Approved.

A-1413—Kamin—New Jersey Declaration of Death Act. Approved.

A-1418—Kamin—Defibrillation/EMT. Permits certain persons to perform defibrillation. **Action Deferred,** pending further discussion by Committee on Emergency Medical Care.

A-1456—Pelly—CPR Instruction. Requires instruction in cardiopulmonary resuscitation to each secondary school pupil. **Approved.**

A-1680—Albohn—Emergency Warning Lights. Permits physicians and surgeons to use emergency warning lights. **No Action.**

A-1768—McEnroe—DOH/Midwife Prenatal Program. Requires commissioner of health to establish a nurse midwife prenatal demonstration program. **Disapproved,** this bill is not clear in its intent and what it hopes to accomplish.

A-2139—Rocco—Fetal Tissue. Requires that fetal remains be examined by a pathologist who shall report his findings to the referring physician. Remains not disposed of by interment shall be incinerated pursuant to the New Jersey State Department of Health regulation. **Conditional Approval,** pending deletion of item #3 from the bill.

A-2270—Farragher—Parental Notification/Abortion. Requires physicians to notify, in writing, the parents of unemancipated minors (less than 18 years of age) 72 hours prior to an abortion. **Disapproved,** this legislation would interfere with the physician/patient relationship and drive young women to seek illegal abortions.

A-2278—Arnone—Emergency Medical Care. Establishes registration system for medical transporter vehicles. **Action Deferred,** pending further discussion by the Committee on Emergency Medical Care.

A-2466—Randall—Medical Power of Attorney. Approved.

A-2467—Randall—Withdrawing/Withholding Life-Sustaining Treatment. Provides for withholding of life-sustaining treatment in absence of medical directive or power of attorney. **No Action.**

A-2492—Randall—New Jersey Health Care Directives Act. Approved.

A-2494—Randall—Fetal Alcohol Syndrome (FAS). Requires sellers of alcoholic beverages to publish a warning regarding FAS. **Approved.**

A-2496—Randall—Tobacco Warnings. Requires sellers of tobacco to post signs warning of the hazards of smoking during pregnancy. **Approved.**

A-2503—Randall—Hospital Records. Requires the commissioner of health to set fees for the copying of hospital records. **No Action.**

A-2514—Randall—New Jersey Health Care Directives Act. Approved.

A-2554—Mattison—AIDS/ARC. Requires hospitals to accept their fair share of AIDS/ARC patients. **Disapproved,** it is unnecessary and unworkable. Incentive, not mandates, should be given to hospitals to accept their fair share of AIDS patients. The New Jersey State Department of Health is setting up programs to assure that no hospital is overburdened with AIDS patients.

A-2613—Naples—School Buses/Seat Belts. Requires school buses to be equipped with seat belts. **Approved.**

A-2639—LoBiondo—Health Needs Study. Requires the commissioner of health to conduct a study of the health needs of low-income persons over the age of 60. **No Action.**

A-2676—Martin—Central Registry/Head Injuries. Requires physicians and hospitals to report patients with head injuries to the New Jersey State Department of Health. **Disapproved,** unworkable legislation—the number of cases would be infinite due to the various types of injuries that would fall within the overly broad system.

A-2699—Martin—Drug Testing/Athletes. Requires high school athletes to be tested for drug abuse. **Disapproved,** because of the lack of confidentiality in the bill.

A-2719—Martin—Organ Donation. Directs the New Jersey Division of Motor Vehicles to redesign the driver's license so that the organ donation form is a part of it. **No Action.**

A-2800—Littell—Health Care Costs. Creates a commission to study the impact of health care costs on employee benefit programs. No physician representation is provided. **No Action.**

A-2801—Littell—Emergency Medical Care. Prohibits formation of local, regional, or statewide emergency medical service coordinating areas. **Disapproved,** this bill would be in conflict with the statewide 911 system.

A-2876—Doyle—Civil Immunity and Disclosure. Requires the reporting of certain potentially violent patients to the police and grants immunity therefore. **Approved.**

A-2878—McEnroe—Organ Transplants. Creates an organ transplant fund and advisory council. **Approved.**

A-2914—Moran—Podiatry. Declares that podiatrists are "physicians" within the scope of their licensing act. **Disapproved,** because the wording of such legislation would mislead the public into assuming that "podiatrists" are fully licensed physicians. If the intent of this bill relates to insurance reimbursement, it should be drafted to change the insurance code. (It was recommended that MSNJ look into previous legislation that usurped the use of the word "physician.")

A-2957—Kronick—Natural Death Act. No Action.

A-2984—Foy—Notification/Agent Orange. Requires physicians who treat veterans who may have been exposed to agent orange to file a report with the New Jersey State Department of Health if the veteran so consents. **Action Deferred,** pending further information from the Council on Public Health.

A-2999—Rooney—Fertility Drugs/Consent. Provides for statutory informed consent related to the administration of fertility drugs. **Disapproved,** infringement on the private practice of medicine.

A-3004—Colburn—DRG. Calls for a DRG study commission. **Approved.**

A-3088—Colburn—Medicaid. Expands Medicaid coverage eligibility for pregnant women to 185 percent of the federal poverty level. **Approved.**

A-3199—Spadoro—Egg Labeling/Public Health. Imposes labeling and identification requirements for the packaging and marketing of eggs and egg-producing poultry for epidemiological purposes. **Approved.**

A-3256—McGreevey—Health Insurance/Drug Abuse. Mandates coverage of treatment for drug abuse as eligible for reimbursement by health insurers. **Approved.**

A-3280—Cimino—Audiologists/Insurance Benefits. Provides that audiologists services are reimbursable under health insurance contracts. **Approved.**

A-3281—Felice—Medicaid/Vaccines. Provides that practitioners can receive at no cost immunization vaccines from the New Jersey State Department of Health to be used for Medicaid patients. **Approved.**

A-3353—Randall—Caller ID. Limits caller ID availability to residential customers, public safety agencies, and hospitals. **No Action.**

A-3368—Farragher—School Health Services/Abortion. Prohibits school health services from dispensing contraceptives, abortifacients, making referrals for abortion, or providing abortion counseling. **No Action.**

A-3389—Bryant—Prescriptions. Requires that prescription benefits in the State Health Benefits Program (state employees) shall apply equally to local pharmacies and any mail-service program. **Conditional Approval,** pending amendment requiring that the mail-service programs adhere to the standards of the New Jersey pharmaceutical laws.

A-3434—Deverin—Occupational Therapists. Provides for the licensing and regulation of occupational therapy. **No Action.**

A-3568—Colburn—Bone Marrow Transplants. Requires that hospitals be reasonably reimbursed for bone marrow transplants. **Approved.**

A-3653—Mazur—Draize Test. Prohibits the use of the Draize test after January 1992 and places severe limitations prior to that time. **Disapproved,** the use of research animals is necessary to protect the public and advance scientific study.

A-3664—Penn—Health Care Facilities/Psychologists. Provides that health care facilities must grant privileges to psychologists. **Disapproved,** psychological services do not meet the severity of illness and intensity of service standards of acute care hospitals.

A-3732—Naples—School Buses. Requires certain seat height and seat belts on school buses; requires use of seat belts on school buses. **Approved.**

A-3800—Pelly—Health Insurance. Requires health insurers to provide coverage for preventive health services, places a cap on the amount of liability therefore, and provides for an annual adjustment based on the Consumer Price Index. **Approved.**

A-3829—Bryant—Abused Children. Expands definition of abused child to include drug-addicted infants and children of drug abusing parent or guardian. **Approved.**

A-4022—Bush—HIV Testing of Newborns. Requires newborns to be tested for the HIV sensitivity unless the parents express a written objection. **Approved.**

A-4023—Bush—Newborn Testing. Provides all newborns shall be tested for the presence of controlled dangerous substances (CDS) unless the parents object based upon religious belief. **Approved.**

A-4082—Roberts—Blood Transfusions (same as **S-3053**). This bill establishes the "Blood Safety Act of 1990." The bill requires that if a blood transfusion is likely to be necessary during surgery, a physician or surgeon must inform his patient of blood transfusion options, that is autologous, designated, and homologous blood transfusions. The physician or surgeon then would note on the patient's medical record that all blood transfusion options have been explained to the patient prior to surgery. **Action Deferred,** further information is being requested from the New Jersey Society of Pathologists, the New Jersey Chapter, American College of Surgeons, and the blood banks.

1990 House of Delegates
Resolution #2—Alternative to Tort Reform

Resolved, that an ad hoc committee of the Medical Society of New Jersey be established to coordinate tort reform objectives and to look into realistic alternatives to tort reform that would work in New Jersey.

The Medical Society of New Jersey and the Medical Inter-Insurance Exchange of New Jersey are working together to promote an intensive broad-based comprehensive program to get legislation relating to tort reform passed. The Council is actively supporting **S-2637**—Senator Dalton's bill on structured verdicts.

Resolution #14—Good Samaritan Immunity

Resolved, that this proposal be forwarded to the AMA for national consideration.

The Council deferred action on Resolution #14 pending future legislation emanating from the "Governor's Commission on Health Care Costs Report" issued on October 1, 1990.

[redacted]

The Reference Committee recommended that the report be filed.
HOUSE ACTION: Adopted. The report was filed.

SUPPLEMENTAL REPORT #1: COUNCIL ON LEGISLATION

Irving P. Ratner, MD
(Reference Committee "D")

On Tuesday, January 8, 1991, the Senate and General Assembly met for organization of the Second Annual Session of the 294th New Jersey State Legislature. As the Legislature presently is constituted, the Senate has a total of 40 members consisting of 17 Republicans and 23 Democrats. The Assembly has a total of 80 members consisting of 37 Republicans and 43 Democrats. By means of official legislative bulletins, the Society's official legislative positions on all current state legislation are regularly called to the attention of legislators as well as component societies, cooperating agencies, county keymen, county society executive directors, and executive secretaries.

The Society has adopted the following regular range of official positions concerning proposed legislation:

Watch List: For all **Approved/Disapproved** legislation.

Active Support: All-out support for the measure.

Active Opposition: All-out opposition for the measure.

Note and File: For all **No Action** legislation.

Conditional Approval: To indicate that the approval of the Society is conditional, subject to elimination of the unsatisfactory elements of the bill that are pointed out.

Action Deferred: Pending amendment that will have substantial impact on **Active Support/Active Opposition** legislation.

The following bills were signed into law since the compilation of the Council on Legislation's Annual Report.

S-1208-Ambrosio—Declaration of Death. Sets forth the criteria to be recognized for a declaration of death. Neurological criteria may not be used if they violate the personal religious beliefs or moral convictions of the individual. **Active Opposition.**

A-1881-Doria—Podiatry. Permits podiatrists to certify physical disability for handicapped parking privileges. **Approved.**

A-3531-Impreveduto—Nurse Midwives. Authorizes nurse midwives who have registered with the State Board of Medical Examiners to write prescriptions consistent with protocols established by their collaborative physician. **Active Opposition.**

Current Legislation

The Council offers this Supplemental Report #1 covering items dealt with since the compilation of its Annual Report.

Senate Assembly
(Active)

S-3033-Orechio—Worker's Compensation (same as **A-4057**). Requires that when an employer provides a list of designated physicians, at least one chiropractor must be included. **Active Opposition,** today there are various health care delivery systems, i.e. HMOs, PPOs, that employers purchase and these systems define providers by policy. This legislation would prevent employers from selecting the health practitioners that they wish. (It was recommended that MSNJ meet with New Jersey Chamber of Commerce in an effort to create legislation that might lead to a more prudent and more financially responsible program of worker's compensation in the state of New Jersey.)

S-3218-Rice—HIV Testing. Any person convicted of sexual assaults must be tested for HIV sensitivity, and the results of the test are to be disclosed to the victim. **Active Support.**

S-3251-Codey—Health Care Reform. A sweeping omnibus bill that, among other things, applies certificate of need to doctors, prohibits doctors from referring patients to a service in which they own an interest, prohibits dispensing beyond a four-day supply, and provides for a holographic override on generic prescriptions. **Active Opposition,** physicians should not be prohibited from referring patients to a service in which they own an interest since they already are required to disclose their financial interest, and certificates of need should not be required for doctors in private practice.

A-2212-Spadoro—Medical Waste. Imposes criminal penalties for illegal disposal of medical waste; increases criminal penalty for illegal disposal of hazardous waste. **Active Opposition,** physicians who have not had an opportunity to be appropriately educated by the Department of Environmental Protection regarding the generation, transport, storage, or disposal of special medical waste not to comply with the registration act. Current law adequately addresses the issue but a greater effort at meaningful implementation is necessary.

A-3289-Patero—Health Insurance for the Unemployed. Establishes two state-operated plans for the unemployed. Appropriates $50 million from the State Disability Fund as a start-up loan. Continued funding is provided by diversion from the unemployment compensation fund. Anyone collecting unemployment would be eligible for state-sponsored health and life coverage. **Active Opposition,** unnecessary legislation and would create

a disability and worker's compensation insurance crisis.

A-4145-Ford—Commissioner of Health. Amends current law to provide the commissioner of health may be a physician or a nurse. **Active Opposition,** the health care needs of our population require that a licensed physician to serve in the position of commissioner of health.

A-4268-Mullen—Physician Dispensing. Prohibits physicians from dispensing more than a four-day emergency supply of drugs except in certain limited instances. **Active Opposition,** compromises the physician's ability to treat patients properly.

A-4282-(AIC Substitute)—Health Care Reform. Omnibus reform bill that would adversely affect physicians by requiring the prescription of generics except when holographically written and also would apply certificate of need to physicians at the $1 million threshold. **Active Opposition,** certificates of need should not be required for doctors in private practice and the liberalization of the generic law is not indicated at this time.

A-4284-Mullen—Generic Prescriptions. Mandates the use of generic prescriptions unless the prescriber holographically overrides. **Active Opposition,** liberalization of the generic law is not indicated at this time.

A-4303-Catania—HIV Testing. Requires that persons convicted of sexual crimes be tested for HIV sensitivity. **Active Support.**

A-4347-Mullen—Physician Assistants. Provides for the registration of physician assistants through a separate board. A supervising physician is necessary but does not need to be physically present at all times. **Active Opposition,** registration of physician assistants neither will contribute to the quality of medical care nor decrease the cost of medical care and will create confusion in the delivery system.

A-4367 (ACS)-Bush—Medicare Assignment. Mandates acceptance of Medicare rates for senior citizens with incomes of $34,125 (single) and $41,875 (couple). **Active Opposition,** unnecessarily favors wealthy senior citizens to the disadvantage of the middle class and the poor and is unfairly discriminatory against physicians.

A-4468-Pelly—Caller I.D. Requires free blocking services for call blocking for unpublished telephone numbers when caller I.D. is in place. **Active Support.**

A-4483-Rooney—Parental Notification for Abortion. Requires physicians to give an unemancipated minor's parents or guardian at least 48 hours notice prior to performing an abortion. **Active Opposition,** this legislation would interfere with the physician/patient relationship and drive young women to seek illegal abortions.

A-4585-Mullen—Nurse Practitioners. Authorizes nurses to diagnose and treat and to otherwise practice all licensed health professions. **Active Opposition,** nurses are not qualified to make a medical diagnosis nor to prescribe therapeutic medications.

Senate/Assembly
(Monitor)

S-804-Rice—AIDS. Requires hospitals to accept fair share of AIDS patients. **No Action.**

S-1592-Cardinale—Fluoride. Prohibits the addition of fluoride to the water of adult psychiatric facilities that have independent water sources. **Approved.**

S-2282-Bassano—Anabolic Steroids. Classifies anabolic steroids as a "schedule V" drug. **No Action.**

S-2369-Di Francesco—Rights of Psychiatric Patients. Guarantees rights of psychiatric patients in screening services and short-term care facilities. **No Action.**

S-2384-Paterniti—Rights of Psychiatric Patients (same as **A-948**). Guarantees rights of psychiatric patients in screening services and short-term care facilities. **No Action.**

S-3034-Zane—HIV Testing (Marriage License). Requires HIV testing before issuance of a marriage license. **Disapproved,** consenting adults should be able to voluntarily decide whether to be tested.

S-3053-Dalton—Blood Transfusion (same as **A-4082**). This bill establishes the "Blood Safety Act of 1990." The bill requires that if a blood transfusion is likely to be necessary during surgery, a physician or surgeon must inform his patient of blood transfusion options, that is autologous, designated, and homologous blood transfusions. The physician or surgeon then would note on the patient's medical record that all blood transfusion options have been explained to the patient prior to surgery. **Disapproved.**

S-3063-Van Wagner—Immunity. Provides that practitioners treating patients for certain conditions who become aware of the patient being a danger to a known third party must notify the third party or the police of that danger. Immunity is provided for such notification. **Approved.**

S-3086-Di Francesco—Psychiatric Commitments. Defines rights of patients in psychiatric facilities and screening centers. **Approved.**

S-3090-Cafiero—Emergency Services. Provides that hospitals with an accredited EMS may apply to the New Jersey State Department of Health to develop and maintain an intermediate life-support program with local squads under regulations adopted by the commissioner. **Action Deferred,** pending further information from the Committee on Emergency Medical Care and the New Jersey Chapter, American College of Emergency Physicians.

S-3132-Codey—Health Insurance. Requires that health insurers must offer mini-health coverages. These coverages may not be offered to groups that had health coverage in the preceding 12 months. **No Action.**

S-3143-Ambrosio—Psychologists. Requires hospitals to permit psychologists to use hospital facilities on the same basis as physicians. **Disapproved,** psychological services do not meet the severity of illness and intensity of service standards of acute care hospitals.

S-3211-Cowan—Health Insurance. Provides that health insurers must offer preventive health services. A cap is placed on the dollar value of the benefit service that expands with the consumer price index. **Action Deferred,** pending further information from the Council on Public Health.

S-3225-Girgenti—PAAD. Requires that Pharmaceutical Assistance to the Aged and Disabled be revised in accordance with any social security increases that are cost of living based on an annualized basis. **Approved.**

S-3229-Paterniti—Regulatory Board Notices. Requires the New Jersey State Department of Health to forward reports on certain disciplinary matters it receives from licensing boards to the New Jersey State Board of Pharmacy. **No Action.**

S-3265-Feldman—**PAAD.** Increases Pharmaceutical Assistance to the Aged and Disabled limits and ties future increases to social security cost of living adjustments. **No Action.**

S-3320-Haines—**Psychiatric Hospitals.** Creates a 13-member study commission regarding the long-term role of the state psychiatric hospitals and developmental centers. Nine of the members are ex-officio, while four public members will be appointed by the governor. **Disapproved,** unnecessary legislation.

A-732-J. Smith—**AIDS.** Requires isolation of patients with AIDS in state psychiatric hospitals. **Approved.**

A-948-Otlowski—**Rights of Psychiatric Patients** (same as S-2384). Guarantees rights of psychiatric patients in screening services and short-term care facilities. **No Action.**

A-2404-Baer—**Sulfites.** Prohibits sale of food or food products to which sulfites have been added. **Conditional Approval,** pending removal of the exemption of manufacturers and growers from this bill and the addition of a labeling requirement.

A-4082-Roberts—**Blood Transfusion** (same as S-3053). This bill establishes the "Blood Safety Act of 1990." The bill requires that if a blood transfusion is likely to be necessary during surgery, a physician or surgeon must inform his patient of blood transfusion options, that is autologous, designated, and homologous blood transfusions. The physician or surgeon then would note on the patient's medical record that all blood transfusion options have been explained to the patient prior to surgery. **Disapproved.**

A-4161-Felice—**Medicaid.** Expands Medicaid to cover pregnant women and children up to six years of age when family incomes are 133 percent of the federal poverty level. **No Action.**

A-4177-Mecca—**Mammography Technician.** Creates a limited certificate for mammography x-ray technologists. **Disapproved,** there is no demonstrated need for licensure of this occupation as a separate and independent profession.

A-4223-Ford—Lyme **Disease.** Creates a nine-member Governor's Advisory Council. One of the governor's two appointments must be a physician. **Disapproved,** unnecessary legislation.

A-4269-Mullen—**HMO Business Practices.** Prohibits home maintenance organizations (HMOs) from using "trans-o-grams" or other similar billing devices. **No Action.**

A-4301-Deverin—**Health Insurance.** Requires insurers to make available a basic plan for employers with fewer than 25 employees. **Approved.**

A-4333-Cimino—**Health Maintenance Organizations.** Requires HMOs to secure a certificate of authority from the New Jersey State Department of Insurance and otherwise transfers to the New Jersey State Department of Insurance regulatory jurisdiction over financial aspects of HMOs. **Approved.**

A-4351-Impreveduto—**Tattoo Parlors.** Authorizes the State Public Health Council to regulate tattoo parlors. **Approved.**

A-4438-Felice—**Emergency Volunteers.** Requires the New Jersey State Department of Health to provide free vaccinations for hepatitis B to emergency volunteers. **Approved.**

A-4498-Farragher—**Tuberculosis.** Permits a board of education to test new students for tuberculosis if there is no record of a Mantoux test. **Approved.**

A-4699-Brown—**Smokers' Rights.** Prohibits employers from taking certain actions, with respect to employees who smoke or use tobacco products. **No Action.**

[redacted]

The Reference Committee recommended that Supplemental Report #1 be filed.
HOUSE ACTION: Adopted. The Supplemental Report #1 was filed.

RESOLUTION #3

Introduced by: Middlesex County Medical Society
Subject: Funding for University of Medicine and Dentistry of New Jersey
Referred to: Reference Committee "D"

Whereas, the University of Medicine and Dentistry of New Jersey (UMDNJ) is the health care university of the state of New Jersey, and its excellence reflects positively on health care workers, including physicians, in the state; and

Whereas, this young and growing institution requires generous funding at this crucial time for the continuation of current programs, and generation of new programs of excellence requires generous funding; and

Whereas, there is nothing more important to society and the individual as good health, and a major support to our health care system in New Jersey is a strong health care university; now therefore be it

~~**Resolved,** that the Medical Society of New Jersey communicate with the governor and state legislators that state funds to UMDNJ should be increased and not decreased as has been proposed by the governor.~~

Resolved, that the Medical Society of New Jersey communicate to the governor and the Legislature that state funds for the education of medical students at the University of Medicine and Dentistry not be cut out of proportion to the budgetary constraints imposed on the other state agencies or institutions.

[redacted]

Several physicians felt that the resolved should be more specific, limiting the disposition of the requested funding to medical students only.

The Reference Committee recommended that the resolved be amended to read as follows:

Resolved, that the Medical Society of New Jersey communicate with the governor and state legislators that state funds for the education of medical students at the University of Medicine and Dentistry of New Jersey should be increased and not decreased as has been proposed by the governor.

HOUSE ACTION: Not adopted.

The Reference Committee recommended that Resolution #3 be adopted as amended.

HOUSE ACTION: Not adopted. The House of Delegates adopted the Substitute Resolution #3.

RESOLUTION #9

Introduced by: Essex County Medical Society
Subject: Check Seniors' Medications
Referred to: Reference Committee "D"

Whereas, many senior citizens fail to discard outdated medications; and

Whereas, many senior citizens accumulate combinations of medications that could have adverse interactions; and

Whereas, physicians can easily determine and discuss with patients their current medication requirements, dosages, and side effects; and

Whereas, a program of inviting senior citizens to bring all their accumulated medications to their physicians to review appropriateness, dating, dosage, drug interactions, and side effects has been requested by the Essex County Medical Society/Senior Citizens Committee; and

Whereas, such a program will benefit senior citizens and serve as a public relations project; now therefore be it

~~**Resolved,** that the Medical Society of New Jersey adopt a public relations program advising senior citizens to periodically bring all their accumulated medications to their physicians to review appropriateness, dating, dosage, drug interactions, and side effects; and be it further~~

~~**Resolved,** that there be published advertisements and articles in *NEW JERSEY MEDICINE* to familiarize physicians with this program; and be if further~~

~~**Resolved,** that county medical societies be encouraged to adopt a similar information program~~.

Resolved, that the Medical Society of New Jersey adopt a public relations program advising senior citizens to take all their accumulated medications, both prescription and over the counter, to their physicians to review appropriateness, dating, dosage, drug interactions, and side effects; and be it further

Resolved, that there be published advertisements and articles in *NEW JERSEY MEDICINE* to familiarize physicians with this program and the existing Auxiliary and Medical Society of New Jersey Medi-File Program; and be it further

Resolved, that county medical societies be encouraged to adopt a similar information program.

The Reference Committee recommended that the first and second resolveds be amended as shown.

HOUSE ACTION: Adopted.

The Reference Committee recommended that Resolution #9 be adopted as amended.

HOUSE ACTION: Adopted. Resolution #9 was adopted as amended by the Reference Committee.

RESOLUTION #14

Introduced by: Ocean County Medical Society
Subject: State Interference with Federal Law
Referred to: Reference Committee "D"

Whereas, Congress enacted Medicare in 1965 in order to provide health care to those over the age of 65; and

Whereas, the Medicare program provided the options for physicians on a case-by-case basis to accept or not to accept Medicare assignment; and

Whereas, the Medicare program has been modified since 1965, including efforts to have physicians enrolled on a participating (accepting assignment on all claims) or nonparticipating basis (accepting or not accepting assignment case-by-case); and

Whereas, Congress has addressed the issue of mandatory participation for all physicians and has not seen fit to change the mandatory assignment for all participants; and

Whereas, states have legislatively done what Congress saw fit not to do, i.e. adopted legislation to mandate accepting of assignment for all participants; and

Whereas, the impact of mandatory assignment ultimately will affect access to health care by Medicare recipients as well as jeopardize care in rural and remote areas; and

Whereas, Congress and Medicare recipients have resisted a means test for the Medicare program in spite of uncontrolled costs resulting from a variety of causes; now therefore be it

Resolved, that the Medical Society of New Jersey seek support for congressional legislation that would prohibit states from interfering with federally funded programs that states have not contributed in funding.

[redacted]

The Reference Committee understood and was sympathetic with the intent of Resolution #14, but felt that it did not realistically address a problem subject to correction by Congress. It already is settled law that a state cannot interfere with federal law.

The Reference Committee recommended that Resolution #14 be rejected.

HOUSE ACTION: Adopted. Resolution #14 was rejected.

RESOLUTION #15

Introduced by: Bergen County Medical Society
Subject: Interest Rate Charges
Referred to: Reference Committee "D"

Whereas, physicians are permitted to charge interest for unpaid balances due; and

Whereas, the current permissible interest rate is unreasonably low and is not a sufficient impetus to stimulate prompt payment of fees to physicians, thereby creating essentially interest free or low-rate loans to insurance companies and patients; now therefore be it

Resolved, that the Medical Society of New Jersey Board of Trustees be instructed to seek legislation that permits physicians to charge any interest rate that is nonusurious.

[redacted]

Opinion regarding the charging of interest rates was divided. Further, it was felt that it is not the Reference Committee's purview to amend a Judicial Council opinion.

It was noted, that, absent the Council opinion, doctors currently are permitted to charge whatever nonusurious interest rate they choose provided an agreement has been reached between the physician and patient prior to service. Such decisions have no impact on insurance companies.

The Reference Committee recommended that Resolution #15 be referred to the Judicial Council for reconsideration.

HOUSE ACTION: Adopted. Resolution #15 was referred to the Judicial Council for reconsideration.

INFORMATIONAL REPORT

Committee on Medical Education
Palma E. Formica, MD

There were frequent meetings of the Committee on Medical Education during the past year. Twelve hospitals were reaccredited, 2 additional hospitals have inquired about being accredited, 4 other hospitals were granted provisional accreditation, 1 hospital was placed on probation, and 3 hospitals lost accreditation.

There were six meetings of a subcommittee on focused medical education in which MSNJ acted as facilitator. The New Jersey State Board of Medical Examiners, the University of Medicine and Dentistry of New Jersey, the Medical Inter-Insurance Exchange of New Jersey, the Academy of Medicine of New Jersey, and the Hospital Medical Staff Section participated in developing a proposed administrative outline for the implementation of a focused medical education program. The Board of Medical Examiners' president, Dr. Michael Grossman, accepted the proposed administrative outline on focused medical education prepared by the subcommittee and expressed appreciation to MSNJ and its Committee on Medical Education and hoped the cooperative effort would continue. He has assigned a high priority to this project.

Dr. Grossman indicated the New Jersey State Board of Medical Examiners will assume future responsibility for staffing and funding of the proposed program that will concentrate on physicians who have demonstrated problems in the following areas: substance abuse—personal or prescribed; felons—physicians involved in criminal activity; out-of-date practitioners—physicians who are not practicing state-of-art medicine; lack of basic skills—physicians who do not evidence the ability to do basic medical procedures such as physical examinations, case histories, or properly manage patient care.

Identifying the problem physician and the areas of deficiencies does not present a major difficulty. The crux of the problem is motivating those who recognize the problem physician, but cannot or will not accept the responsibility of reporting. The passage of Senate Bill S-2936 mandates that a physician, medical resident, or intern shall notify the State Board of Medical Examiners that he possesses information that reasonably indicates another practitioner has demonstrated an impairment, gross incompetence, or unprofessional conduct that would present an imminent danger to an individual patient or to the public health, safety, or welfare. A practitioner who fails to notify the Board is subject to disciplinary action and civil penalties. The informant is not liable for damages unless false information was knowingly provided.

The Committee on Medical Education appointed a subcommittee to review and update MSNJ's "Operational Manual for CME." There were several subcommittee meetings and frequent teleconferencing before the revised manual was finalized. Effort was directed to eliminate and prevent future duplication of overlapping areas with particular attention to objectives and needs assessment in the overall restructuring process.

The Committee on Medical Education routinely sends MSNJ's Board of Trustees copies of committee meeting reports to keep the governing body informed of its current activity.

The Committee on Medical Education provides an educational CME seminar annually for hospital DMEs and their staffs on updating CME operational procedures. The program has been well received and the sharing of experience has been most helpful.

Offices Filled By Election
1991 Annual Meeting

Office	Term	Nominee and County
Officer		
President-Elect	1 year	William E. Ryan, MD, Mercer
1st Vice-President	1 year	Joseph N. Micale, MD, Hudson
2nd Vice-President	1 year	Fred M. Palace, MD, Morris
Trustees		
1st District	3 years	Stevan Adler, MD, Morris
4th District	3 years	Irving P. Ratner, MD, Burlington
4th District	3 years	Louis L. Keeler, MD, Camden
5th District	3 years	Shah M. Chaudhry, MD, Cape May
Judicial Councilor		
3rd District	3 years	Louis G. Fares, MD, Mercer
AMA Delegates		
	1 year°	Joseph N. Micale, MD, Hudson
	2 years°°	William E. Ryan, MD, Mercer
	2 years	Joseph N. Micale, MD, Hudson
	2 years	Joseph A. Riggs, MD, Camden
	2 years	Robert H. Stackpole, MD, Union
AMA Alternate Delegates		
	1 year°°°	George T. Hare, MD, Camden
	2 years°°°°	Mark T. Olesnicky, MD, Essex
	2 years	Douglas M. Costabile, MD, Union
	2 years	George T. Hare, MD, Camden
	2 years	Donald J. Holtzman, MD, Union
	2 years	Robert J. Weierman, MD, Essex
Administrative Councils		
Legislation		
5th District	2 years	Narasimhaloo Venugopal, MD, Cumberland
6th Member	2 years	Jerome A. Molitor, MD, Union
Medical Services		
5th District	2 years	Narasimhaloo Venugopal, MD, Cumberland
6th Member	2 years	Charles L. Cunniff, MD, Hudson
Mental Health		
3rd District	2 years	Douglas H. Robinson, MD, Mercer
6th Member	2 years	Reinaldo C. Alvarez, MD, Union
Public Health		
5th District	2 years	Gerald S. Packman, MD, Cumberland
6th Member	2 years	Francis J. Deitmaring, MD, Hudson
Public Relations		
2nd District	2 years	G. Jerry Falcone, MD, Hudson
5th District	2 years	Kelly M. Reid, MD, Atlantic
Standing Committees		
Annual Meeting	2 years	Russ C. Camangian, MD, Hudson
Finance and Budget	2 years	Vito M. Gulli, MD, Monmouth
Medical Education	2 years	Robert S. Rigolosi, MD, Bergen
Membership Services	1 year°°°°°	Yale C. Shulman, MD, Hudson
	2 years	Patricia G. Klein, MD, Bergen
Publication	2 years	Clement H. Kreider, Jr, MD, Monmouth

°Unexpired term of Frank Y. Watson, MD, who resigned January 11, 1991.
°°Vacancy created by resignation of Frederick W. Durham, MD, on December 31, 1990.
°°°Unexpired term of William E. Ryan, MD.
°°°°Unexpired term of Joseph N. Micale, MD.
°°°°°Unexpired term of Donald J. Cinotti, MD, who resigned January 29, 1991.

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for
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A **$500 AWARD** will be presented annually by the Medical Society of New Jersey to the intern, resident, fellow, or 4th-year medical student who submits the best paper on a clinical subject for the Society's 1991 Competition.

Entries should be "sponsored" by a faculty member, and all papers submitted should be of sufficient quality to be considered for publication in NEW JERSEY MEDICINE.

Entrants need not be members of the Medical Society of New Jersey, but must be in training at a New Jersey hospital, studying at an institution in the state of New Jersey, or be a resident of New Jersey.

Entries must be submitted by November 1, 1991. The winning paper will be published in a future issue of NEW JERSEY MEDICINE. Other noteworthy manuscripts will be considered for publication by the Editorial Board of NEW JERSEY MEDICINE. Editorial criteria appear at the end of the issue.

Send two copies of the manuscript to:

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UROLOGY RESIDENT—Seeks practice opportunity in NJ. Trained in all aspects of Urology at Columbia-Presbyterian. Available July 1992. Board Eligible. Excellent credentials. Contact John Giella, MD, 64 W. 9th St., Apt. #5S, New York, NY 10011. 212-228-7562.

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INTERNIST—Board Certified/Board Eligible. Looking for part-time physician to join a busy 2 person practice in a growing South Jersey community, minutes from Philadelphia. Rheumatology interests encouraged. Send CV to Box No. 420, NEW JERSEY MEDICINE.

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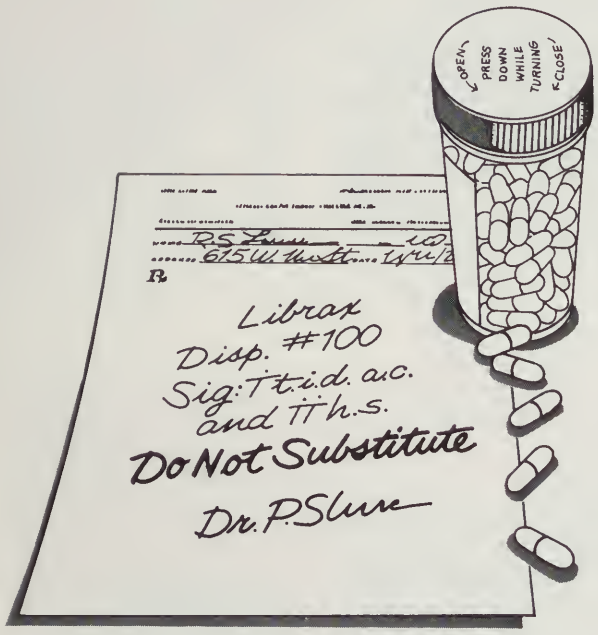
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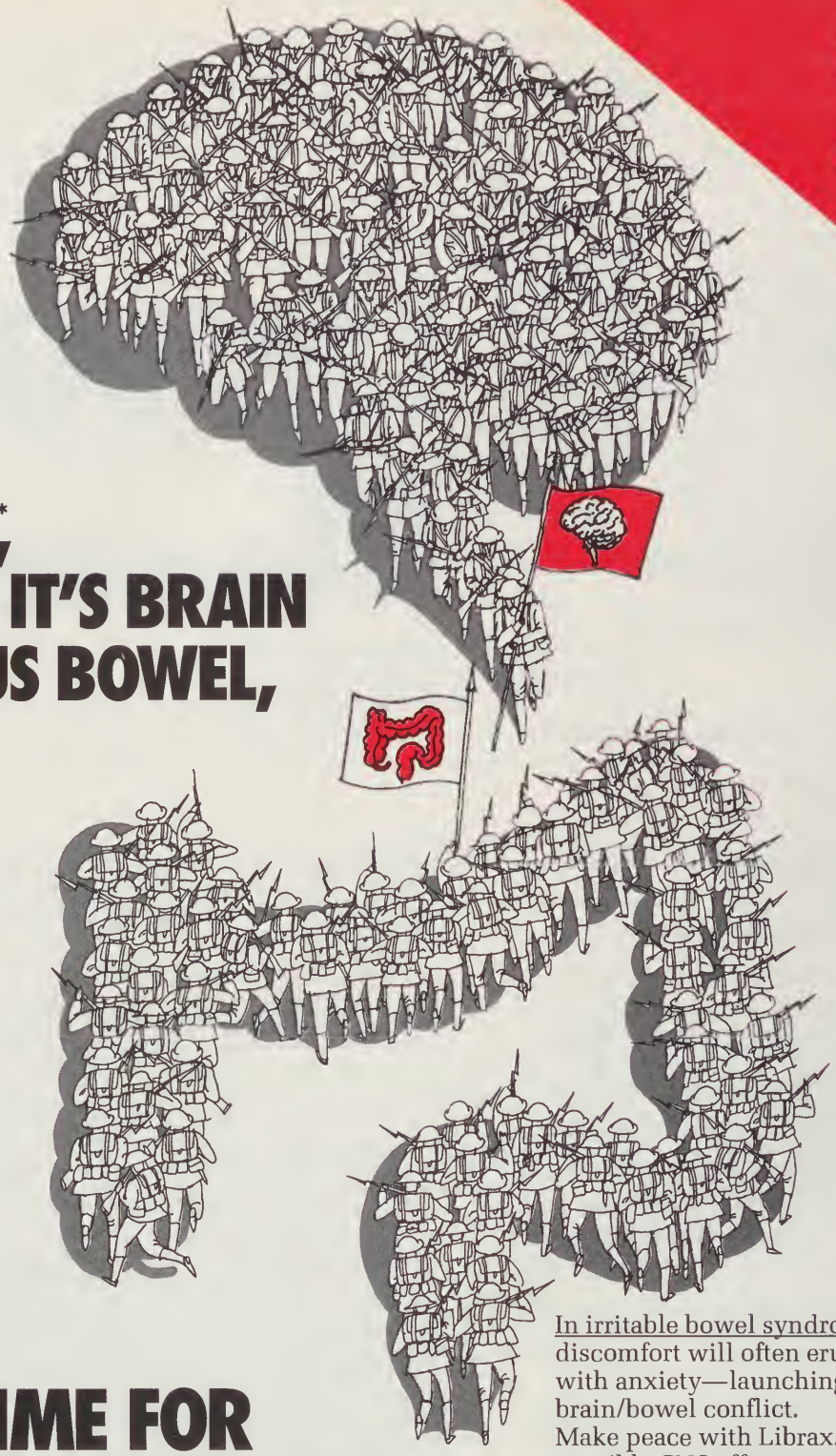
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Newswatch

LICENSING RENEWAL--1991...

MSNJ objected to inappropriate and pervasive questions on the medical license renewal form. When the State Board of Medical Examiners (SBME) and the attorney general's office would not amicably agree to revisions, MSNJ filed suit. In late June, the Appellate Division of the Superior Court issued an order striking certain questions, amending others, and directing SBME to mail out a properly revised application. The revised renewal process now is under way and is extended to August 31. The Court also ordered that information gathered by SBME in an improper fashion through the initial form may not be used for investigating or disciplinary purposes.

RESOURCE-BASED RELATIVE VALUE SCALE STUDY...

MSNJ and the American Medical Association (AMA) have strongly objected to the Health Care Financing Administration (HCFA) notice of rule making on the Medicare fee schedule. If adopted, the proposal will make it impossible to serve properly Medicare patients and will produce a lack of access to care for the elderly.

HIV...

The United States Senate, in a highly emotional and perhaps irrational session, voted overwhelmingly to mandate HIV testing for physicians and health care workers and to require

disclosure of HIV positivity to patients. Failure to disclose would incur fines and penalties and potential imprisonment. AMA and MSNJ officials have urged vigorously New Jersey congressmen to reject the Senate legislation.

HEALTH CARE REFORM--NEW JERSEY...

S-3251/A-5000 was signed into law by Governor Florio on July 1, 1991. MSNJ was successful in deleting a number of elements adverse to medicine and in modifying others. Medical equipment expenditures in excess of $1 million will require a certificate of need. Physicians, however, can apply for exemptions if necessary to their specialty. All existing facilities are exempt.

After July 31, 1991, physicians may not establish centers to which they refer patients when the service is not part of their practice. Radiation oncology, lithotripsy, and renal dialysis services are exempt. Also, any centers in existence before July 31 are exempt.

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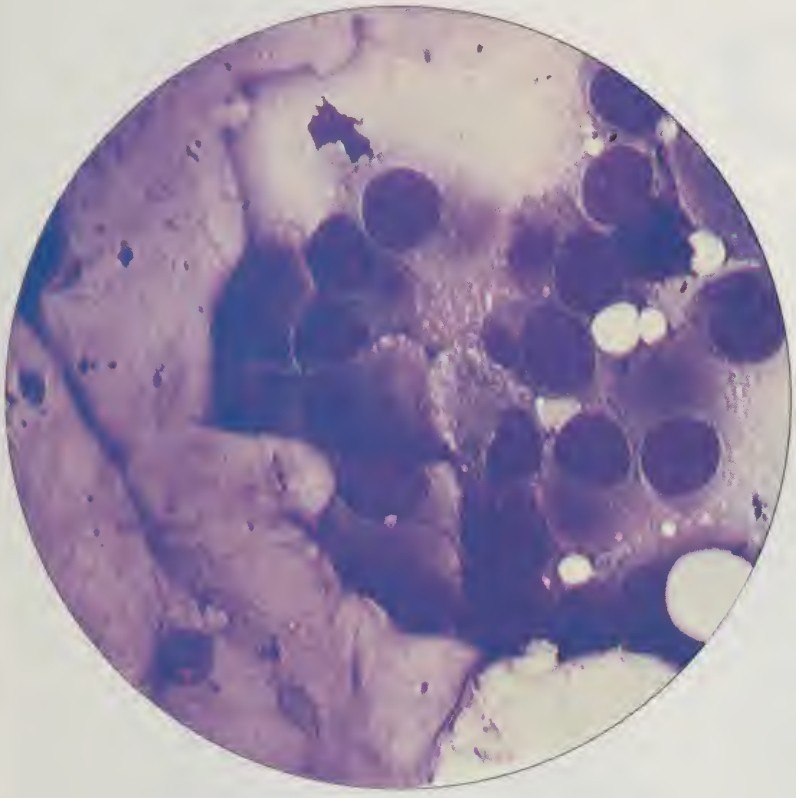
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The Cover

The history of renal disease and its treatment by New Jersey physicians are uncovered in two articles, beginning on page 549. Cover: Williams & Philips.

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Tumor Marker Panels: The Future of Treatment Planning for Breast Cancer

David E. Burnstein, M.D.
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Growth Factors, Oncogenes and Antioncogenes: Possible Diagnostic Application

Stephen A. Feig, M.D.
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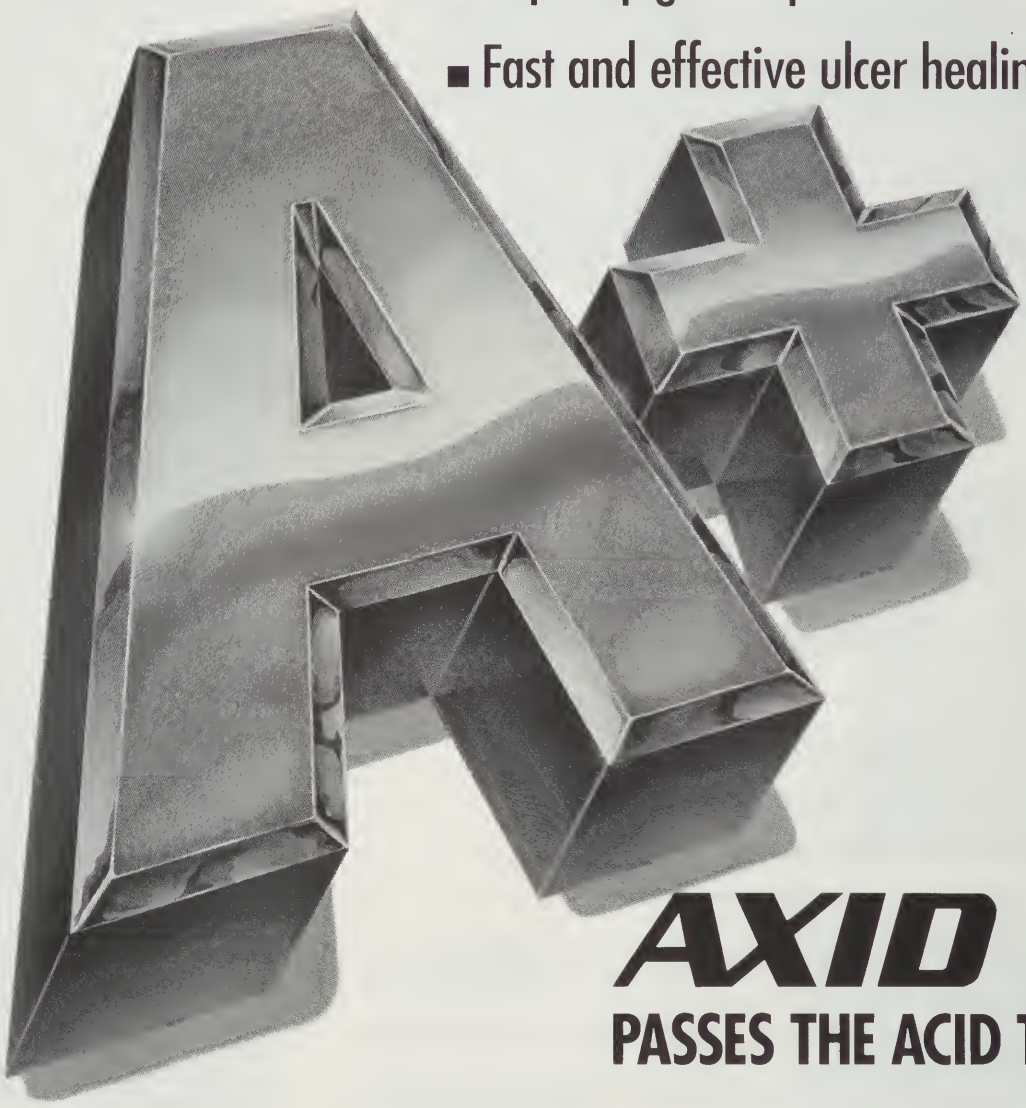
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AXID ® (nizatidine capsules)

Brief Summary. Consult the package insert for complete prescribing information.
Indications and Usage: 1. *Active duodenal ulcer*—for up to 8 weeks of treatment. Most patients heal within 4 weeks.

2. *Maintenance therapy*—for healed duodenal ulcer patients at a reduced dosage of 150 mg h.s. The consequences of therapy with Axid for longer than 1 year are not known.

Contraindications: Known hypersensitivity to the drug. Because cross sensitivity in this class of compounds has been observed, H_2-receptor antagonists, including Axid, should not be administered to patients with a history of hypersensitivity to other H_2-receptor antagonists.

Precautions: *General*—1. Symptomatic response to nizatidine therapy does not preclude the presence of gastric malignancy.

2. Dosage should be reduced in patients with moderate to severe renal insufficiency.

3. In patients with normal renal function and uncomplicated hepatic dysfunction, the disposition of nizatidine is similar to that in normal subjects.

Laboratory Tests—False-positive tests for urobilinogen with Multistix® may occur during therapy.

Drug Interactions—No interactions have been observed with theophylline, chlordiazepoxide, lorazepam, lidocaine, phenytoin, and warfarin. Axid does not inhibit the cytochrome P-450 enzyme system; therefore, drug interactions mediated by inhibition of hepatic metabolism are not expected to occur. In patients given very high doses (3,900 mg) of aspirin daily, increased serum salicylate levels were seen when nizatidine, 150 mg b.i.d., was administered concurrently.

Carcinogenesis, Mutagenesis, Impairment of Fertility—A 2-year oral carcinogenicity study in rats with doses as high as 500 mg/kg/day (about 80 times the recommended daily therapeutic dose) showed no evidence of a carcinogenic effect. There was a dose-related increase in the density of enterochromaffin-like (ECL) cells in the gastric oxyntic mucosa. In a 2-year study in mice, there was no evidence of a carcinogenic effect in male mice, although hyperplastic nodules of the liver were increased in the high-dose males as compared with placebo. Female mice given the high dose of Axid (2,000 mg/kg/day, about 330 times the human dose) showed marginally statistically significant increases in hepatic carcinoma and hepatic nodular hyperplasia with no numerical increase seen in any of the other dose groups. The rate of hepatic carcinoma in the high-dose animals was within the historical control limits seen for the strain of mice used. The female mice were given a dose larger than the maximum tolerated dose, as indicated by excessive (30%) weight decrement as compared with concurrent controls and evidence of mild liver injury (transaminase elevations). The occurrence of a marginal finding at high dose only in animals given an excessive and somewhat hepatotoxic dose, with no evidence of a carcinogenic effect in rats, male mice, and female mice (given up to 360 mg/kg/day, about 60 times the human dose), and a negative mutagenicity battery are not considered evidence of a carcinogenic potential for Axid.

Axid was not mutagenic in a battery of tests performed to evaluate its potential genetic toxicity, including bacterial mutation tests, unscheduled DNA synthesis, sister chromatid exchange, mouse lymphoma assay, chromosome aberration tests, and a micronucleus test.

In a 2-generation, perinatal and postnatal fertility study in rats, doses of nizatidine up to 650 mg/kg/day produced no adverse effects on the reproductive performance of parental animals or their progeny.

Pregnancy—Teratogenic Effects—Pregnancy Category C—Oral reproduction studies in rats at doses up to 300 times the human dose and in Dutch Belted rabbits at doses up to 55 times the human dose revealed no evidence of impaired fertility or teratogenic effect; but, at a dose equivalent to 300 times the human dose, treated rabbits had abortions, decreased number of live fetuses, and depressed fetal weights. On intravenous administration to pregnant New Zealand White rabbits, nizatidine at 20 mg/kg produced cardiac enlargement, coarctation of the aortic arch, and cutaneous edema in 1 fetus, and at 50 mg/kg, it produced ventricular anomaly, distended abdomen, spina bifida, hydrocephaly, and enlarged heart in 1 fetus. There are, however, no adequate and well-controlled studies in pregnant women. It is also not known whether nizatidine can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Nizatidine should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers—Studies in lactating women have shown that 0.1% of an oral dose is secreted in human milk in proportion to plasma concentrations. Because of growth depression in pups reared by treated lactating rats, a decision should be made whether to discontinue nursing or the drug, taking into account the importance of the drug to the mother.

Pediatric Use—Safety and effectiveness in children have not been established.

Use in Elderly Patients—Healing rates in elderly patients were similar to those in younger age groups as were the rates of adverse events and laboratory test abnormalities. Age alone may not be an important factor in the disposition of nizatidine. Elderly patients may have reduced renal function.

Adverse Reactions: Clinical trials of varying durations included almost 5,000 patients. Among the more common adverse events in domestic placebo-controlled trials of over 1,900 nizatidine patients and over 1,300 on placebo, sweating (1% vs 0.2%), urticaria (0.5% vs <0.01%), and somnolence (2.4% vs 1.3%) were significantly more common with nizatidine. It was not possible to determine whether a variety of less common events were due to the drug.

Hepatic—Hepatocellular injury (elevated liver enzyme tests or alkaline phosphatase) possibly or probably related to nizatidine occurred in some patients. In some cases, there was marked elevation (>500 IU/L) in SGOT or SGPT and, in a single instance, SGPT was >2,000 IU/L. The incidence of elevated liver enzymes overall and elevations of up to 3 times the upper limit of normal, however, did not significantly differ from that in placebo patients. All abnormalities were reversible after discontinuation of Axid. Since market introduction, hepatitis and jaundice have been reported. Rare cases of cholestatic or mixed hepatocellular and cholestatic injury with jaundice have been reported with reversal of the abnormalities after discontinuation of Axid.

Cardiovascular—In clinical pharmacology studies, short episodes of asymptomatic ventricular tachycardia occurred in 2 individuals administered Axid and in 3 untreated subjects.

CNS—Rare cases of reversible mental confusion have been reported.

Endocrine—Clinical pharmacology studies and controlled clinical trials showed no evidence of antiandrogenic activity due to nizatidine. Impotence and decreased libido were reported with equal frequency by patients on nizatidine and those on placebo. Gynecomastia has been reported rarely.

Hematologic—Fatal thrombocytopenia was reported in a patient treated with nizatidine and another H_2-receptor antagonist. This patient had previously experienced thrombocytopenia while taking other drugs. Rare cases of thrombocytopenic purpura have been reported.

Integumental—Sweating and urticaria were reported significantly more frequently in nizatidine- than in placebo-treated patients. Rash and exfoliative dermatitis were also reported.

Hypersensitivity—As with other H_2-receptor antagonists, rare cases of anaphylaxis following nizatidine administration have been reported. Rare episodes of hypersensitivity reactions (eg, bronchospasm, laryngeal edema, rash, and eosinophilia) have been reported.

Other—Hyperuricemia unassociated with gout or nephrolithiasis was reported. Eosinophilia, fever, and nausea related to nizatidine have been reported.

Overdosage: Overdoses of Axid have been reported rarely. If overdosage occurs, activated charcoal, emesis, or lavage should be considered along with clinical monitoring and supportive therapy. Renal dialysis does not substantially increase clearance of nizatidine due to its large volume of distribution.

PV 2091 AMP
[091190]

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1. Data on file, Lilly Research Laboratories.
2. *Scand J Gastroenterol.* 1987;22(suppl 136):61-70.
3. *Scand J Gastroenterol.* 1987;22(suppl 136):47-55.
4. *Am J Gastroenterol.* 1989;84:769-774

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MSNJ NEWSLETTER

MEDICINE AND THE MEDIA

The Medical Society of New Jersey and the Medical Society of New Jersey Auxiliary are co-sponsoring a workshop, "Medicine and the Media," on September 25, 1991, from 9:00 A.M. to 12 NOON. The workshop, focusing on various practical techniques used to develop the art of communication, includes two presentations: "How To Present Yourself in Public," and "Newspaper Coverage of Medical Topics." The conference is free of charge; reservations can be made by contacting MSNJ headquarters at 609/896-1766.

MEDICAID COVERAGE FOR NEWBORNS

The Division of Medical Assistance and Health Services has submitted amendments for the *New Jersey Care ... Special Medicaid Programs Manual* (N.J.A.C. 10:72) to the Office of Administrative Law. The amendments appeared in the June 17, 1991, issue of *New Jersey Register* (23 N.J.R. 1889(a)). The purpose of the amendments is to extend Medicaid eligibility to infants born to Medicaid-eligible women. Eligibility criteria for low-income pregnant women have been established at more inclusive levels than those applied to other recipients, in order to provide health care for the mothers and their unborn children considered to be at risk. The present extension of Medicaid coverage to newborns is a further development of that concern. Full text of the proposal appeared in the *New Jersey Register.*

SEX BIAS IN MEDICINE

Citing new evidence of gender bias in medical care, the president of MSNJ, Dr. Riggs, has called on physicians "to re-examine practice patterns to assure full sexual equality." A report in *JAMA* noted kidney transplantation, heart disease, and lung cancer as areas where women patients may be disadvantaged.

Physicians in New Jersey must satisfy themselves that no patient receives inadequate attention or insufficient diagnostic testing for reasons of gender. "We must be especially careful that women's medical problems are not sloughed off as trivial emotional complaints," stated Dr. Riggs.

To promote the elevation of women to leadership roles in MSNJ, Dr. Riggs has established a Working Group on Women in Medicine.

MEDICARE SCREEN RELEASE PROJECT

The Omnibus Budget Reconciliation Act of 1990 called for a study to assess the effect of the release of Medicare prepayment medical review screen parameters on physician billings. Under the demonstration that started March 1, 1991, seven national medical review parameters were released randomly (no more than four screens per area) in 13 areas.

The original study called for the screens to be released by at least six carriers. With AMA urging, the number of sites was increased substantially to achieve a more representative sampling of large and small carriers, as well as geographic areas. The seven screens are: routine foot care; comprehensive office visits; comprehensive visits in other settings;

skilled nursing facility visits; chiropractic; intermediate hospital visits; and consultations.

The number and choice of parameters released differ from carrier to carrier and range from one to four. Exceeding a screen's parameter does not mean automatic denial of your claim. It only flags your claim for extra review. The carriers participating in the study are: Transamerica Occidental in southern California; Group Health Insurance in New York City; Aetna in Georgia; Travelers in Connecticut; Wisconsin Physicians Service; Equicor in Idaho; Blue Cross and Blue Shield of Alabama; Arkansas Blue Cross and Blue Shield; Blue Cross and Blue Shield of Colorado; Blue Cross and Blue Shield of Indiana; Blue Cross and Blue Shield of Kansas, Inc.; Blue Cross and Blue Shield of Kentucky, Inc.; and Blue Cross and Blue Shield of Texas, Inc.

The Health Care Financing Administration (HCFA) will review changes in utilization, payment levels, and variations between regions and screens. They will be monitoring not only whether physician behavior changes, but to what degree. Results are to be reported to Congress by October 1, 1992.

AMA Policy. The AMA supports requesting HCFA to instruct all Medicare carriers to release to individual providers the parameters used to generate "Medicare Denial Letters" (Res. 126, I-89). Based on supportive physician reaction, the AMA will continue to push for screen disclosure to all physicians in all areas.

COMPARATIVE PERFORMANCE REPORT

The Omnibus Budget Reconciliation Act of 1990 required the Department of Health and Human Services to monitor and profile physicians' billing patterns within each area of locality and to provide comparative data to physicians whose utilization patterns vary significantly from other physicians in the same payment area or locality. This became known as the comparative performance report (CPR).

The CPR program was designed to provide physicians who have unusually high utilization rates with information on where they stand in relation to their peers. The notices were entirely educational and were sent to a limited number of physicians. Although not required to respond to these informational reports, physicians were encouraged to evaluate their coding, billing, and practice patterns to determine why their utilization patterns are different from their peers, and to contact the carrier to discuss their findings.

Physicians also were encouraged to prepare a written explanation of why their statistics vary from those of their peers. In this way, physicians could explain their patient mix, their subspecialty, or any other aspect of their practice that might cause it to differ from their peers' practices.

AMA Policy. The AMA is to work to ensure that the physician profiling criteria and Medicare carrier instructions that are to be used in the Medicare CPR program are developed in a reasonable manner, and that the Medicare CPR program focuses on educational efforts.

In response to AMA lobbying, HCFA made the following changes: Letters will be sent to 1 percent of physicians treating Medicare patients (down from 2 percent). Selections to be made will be based on frequency data rather than dollar thresholds. Physicians will be contacted by telephone before letters are mailed to verify specialty designation. State medical societies will be briefed by carrier personnel before individual physician letters are sent.

The AMA continues to work with HCFA to ensure that the Medicare CPR program is an educational effort. □

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Action: Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalmic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

Indications: Yocon® is indicated as a sympathicolytic and mydriatric. It may have activity as an aphrodisiac.

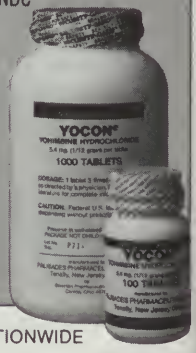
Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.[1,2] Also dizziness, headache, skin flushing reported when used orally.[1,3]

Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.[1,3,4] 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to ½ tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.[3]

How Supplied: Oral tablets of Yocon® 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.



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PROFESSIONAL LIABILITY

MALPRACTICE VERDICTS

A $9 million malpractice judgment against an anesthesiologist and an anesthesiology resident was awarded by a Passaic County jury in February 1991. The case involved a five-month-old baby in a persistent vegetative state following hip surgery. The alleged negligence included a failure to have available during the surgery an endotracheal tube for the baby, whose prior health difficulties included microencephalopathy. The jury allocated 20 percent of the responsibility to the resident and 80 percent to the anesthesiologist, who had previously settled with the plaintiff. *Williams v. Agarwal et al.* (Docket # L-06315-87, Salerno J, Feb. 5, 1991).

In March 1991, a jury in Union County awarded more than $3.7 million for an obstetrician's failure to perform an immediate cesarean section when a second twin presented in face mentum posterior position. High forceps were used in the delivery. Compensated injuries included the loss of most use of both hands, and emotional damage to the parents. *Grinbaum v. DiBenedetto* (Docket # L-97269-88, Weiss J, Mar. 19, 1991).

MALPRACTICE POLICY DEVELOPMENTS

One percent of hospital cases involve medical negligence, and only 1 percent of such cases of negligence result in a malpractice claim payment, according to a Harvard Medical Practice Study of New York State cases. The study found that, although only 2 percent of negligently handled cases actually result in a malpractice claim, physicians on average mistakenly believe that 60 percent of such cases result in a claim. The study also found that the total cost of malpractice premiums in a state was $1.1 billion in 1988. These findings and those from other studies are generating reappraisals of the malpractice system. (*Abridge*, Princeton, NJ, Robert Wood Johnson Foundation, spring 1991).

In a two-volume report, the prestigious American Law Institute recommended awarding damages for pain and suffering only in cases of severely injured patients. The study report, "Enterprise Responsibility for Personal Injury," proposed shifting most liability toward hospitals and away from individual physicians. (*Medical Liability Monitor*, May 21, 1991.)

The Bush administration has proposed a Health Care Liability and Quality of Care Improvement Act to provide funds to states that enact several malpractice reforms, including a $250,000 cap on awards for pain and suffering and a pretrial dispute resolution mechanism. The funds would be provided through withholding of Medicare payments to hospitals. An equivalent cap has been proposed by Senator Hatch (R-UT) in the Ensuring Access Through Medical Liability Reform Act, endorsed by the American Medical Association (AMA) and reintroduced in May as S-489. (*HMSS*, AMA, May 1991).

MSNJ President Joseph A. Riggs, MD, endorsed the proposed malpractice cap. Dr. Riggs expressed his views in a column published opposite the editorial page in the June 6, 1991, *Bergen Record*.

Between 1988 and 1989, the amount of an average jury award for medical malpractice rose half of 1 percent to about $1,110,000, according to the AMA Depart-

ment of Professional Liability and Insurance. This average is a mean and not a median and, therefore, is kept high by a relatively small number of awards of large amounts.

ECONOMIC CREDENTIALING

Economic credentialing refers to hospitals' efforts to permit practice only by physicians who generate sufficient revenue for the hospital. In a Florida case touted as a landmark decision by the Florida Physician's Association, Inc. (a sister organization to the Florida Medical Association), a judge enjoined a hospital from implementing a new exclusive contract with a radiation oncologist in a way that effectively terminated another therapeutic radiologist's practice in the hospital. *Bilek v. Tallahassee Memorial Regional Medical Center, Inc., and Wickstrum* (Leon Cty., Case #91-973, Hall J, Apr. 29, 1991).

A somewhat similar ruling was made by the Tennessee Supreme Court in March 1991, in another case involving a radiologist, *Lewisburg Community Hospital v. Alfredson.* The Tennessee case did not involve economic credentialing per se, but the court found a breach of contract when the hospital prohibited the radiologist from using the hospital's radiology equipment. Like the plaintiff in *Bilek,* the Tennessee radiologist held staff privileges that the hospital was effectively revoking without following proper procedures. (*American Medical News,* Apr. 15, 1991.)

By contrast, an appeals court in California permitted a hospital to move from an open system of anesthesiology to a closed system. The move was prompted by chronic problems. *Mateo-Woodburn v. Fresno Community Hospital and Medical Center,* 270 Cal. Rep. 894 (Ct. of Appl., June 28, 1990). (*The Citation,* Feb. 15 1991).

COMMUNICATION WITH AND ABOUT PATIENTS

The spring 1991 issue of *Info Trends: Medicine, Law & Ethics,* published by Robert Wood Johnson Medical School, featured discussion of a February 11, 1991, ruling by the New Jersey Supreme Court in a case involving patient confidentiality. In the case, *State v. Schreiber,* 91 N.J. 579, 585 A.2d 945, the state high court unanimously affirmed a drunk driving conviction that was based on information volunteered to police by an emergency physician.

The physician called police 1 day after a patient's hospital discharge—1 day before the 30-day statute of limitations for motor vehicle offenses would expire—to report that the patient had presented in the hospital emergency department with a blood alcohol level of 0.26 percent following an automobile accident.

The court left open the question of whether the physician's action violated professional ethics, but ruled that the information was not protected under the physician-patient privilege. The basis of the ruling was that New Jersey law applies the privilege to civil cases, criminal cases, disorderly persons, and juvenile cases—not to motor vehicle cases. The court decision reaffirmed the importance of legal action "to curb the senseless havoc and destruction caused by intoxicated drivers."

In a historic decision characterized as "terrible" by the president of the American College of Obstetricians and Gynecologists, the U.S. Supreme Court upheld federal regulations that prohibit physicians in family planning clinics from providing abortion counseling or referrals. The case, *Rust v. Sullivan,* involved both freedom of speech and abortion rights. Justice Thurgood Marshall, who is retiring after 24 years on the Court, was part of the minority in the 5-4 decision.

OTHER DEVELOPMENTS

The Blood Safety Act signed into law by Governor Jim Florio requires physicians, prior to performing surgical procedures that may necessitate blood transfusions, to inform the patient of the options of autologous, homologous, and designated blood transfusions.

The federal Safe Medical Devices Act of 1990, in provisions that take effect November 28, 1991, requires hospitals and other health facilities to report to manufacturers information that "reasonably suggests" a medical device caused an injury. When the injury is fatal or the manufacturer is unknown, the report must be filed with the FDA.

Physicians may face malpractice liability for "wrongful births" after failing to inform reproductive patients about prenatal and carrier screening tests, advised legal commentators on the Human Genome Project that is mapping all human genes. (*American Medical News,* April 22-29, 1991).

The Pennsylvania Medical Society and the Medical Society of the State of New York are litigating against state restrictions on Medicare balance billing. The suits protest state efforts to be more restrictive than the federal government. (*This Week,* May 20, 1991.)

Senator John East (R-NC) was not a fatal victim of malpractice, ruled a federal district court. Congressional physicians had failed to diagnose the senator's hypothyroidism, and he subsequently became increasingly depressed and committed suicide. *East v. U.S.,* 745 F.Supp. 1142 (D.Md., 1990). (*The Citation,* April 15, 1991).

HIV testing issues, including factors for hospital medical staffs to consider in developing testing policies, will be discussed October 30, 1991, at a conference at the Lawrenceville offices of the Medical Society of New Jersey. Cosponsors of the conference are the New Jersey Hospital Association, Academy of Medicine of New Jersey, and Health Research and Educational Trust. For more information call 1/609/275-4115.

LIABILITY FOR NURSING HOME CARE

Until recently, nursing homes and nursing home physicians were considered protected against malpractice liability, due to the difficulty of proving negligence in geriatric medicine and because infirm elderly retirees do not sustain economic damages such as loss of earnings. In a 1990 Alabama case, however, a state supreme court upheld a $2 million judgment against a nursing home for diverse acts of negligence involving the care and death of a patient in a persistent vegetative state with decubitus ulcers. The jury verdict in the case was in favor of the physician, though. *Montgomery Health Care Facility, Inc. v. Ballard,* 565 So.2d 221. (*The Citation,* April 1, 1991).

And, in Florida, a physician was indicted for manslaughter in the case of a diabetic 83-year-old nursing home resident. The physician, Jack Kenneth Swords, MD, was medical director at the nursing home, located in Key West. The patient's insulin regimen had not been resumed following his readmission. The law case is remarkable in that it poses the prospect of imprisonment of a physician for negligent care. (*American Medical News,* April 22-29, 1991).

PROFESSIONAL LIABILITY

This column was prepared by the Medical Society of New Jersey, Department of Professional Liability Control. Director of the Department is James E. George, MD, JD. Collaborating on the commentary is the Director of Special Projects, Neil E. Weisfeld, JD, MSHyg. □

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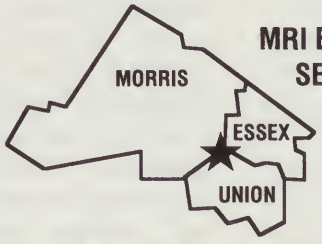
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EDITOR'S DESK



THE INQUISITIVE MIND

We frequently can build on the past by learning from others and by following the stepping stones and lengthening the path. Sometimes we can rewrite history, by refusing to accept the obvious, the logical, or the mandated, and by insisting on proof. "What's your evidence?" was a favorite expression of my old biochemistry instructor. Two articles in the July 1991 issue of *NEW JERSEY MEDICINE* are the subject of this month's editorial. One article illustrates the building-block method of progress. The other article should make us re-examine our thought processes by analyzing the ordinary and commonplace.

Laparoscopic operations represent the star on surgery's horizon. They have been used for years as an adjunct to gynecologic practice. But, for most of its life, laparoscopic surgery existed almost exclusively as a diagnostic tool and for performing tubal ligations. Even these functions were under-utilized; there seemed to be a remarkable lack of cooperation between the general surgeon and the gynecologist. The general surgeon knew how to explore the abdomen, but not how to do laparoscopy. The gynecologist knew how to do laparoscopy, but was loath to do complete abdominal explorations. And a great opportunity was delayed.

But the events of recent years have put endoscopic surgery into high gear. The gynecologists have expanded their techniques, but the advent of laparoscopic cholecystectomy marked the onset of a revolution that shows no sign of abating and whose expansion has exceeded all predictions. In addition to the biliary tract, other areas are being explored—the appendix, the vagus nerve, adhesions, bowel trauma and injuries, the kidney, and the pelvic viscera.

Now the thorax is receiving attention, as noted in the special article, "Video Endscopic Thoracic Surgery," by Doctors Lewis, Caccavale, and Sisler. The authors have utilized, for thoracic procedures, the instrumentation and technologies developed for laparoscopic surgery, including video cameras and multiple ports for the use of assistants, instead of the old, direct-vision thoracoscope that allowed visualization only by the chief operator looking through the eyepiece. As suggested in this brief, preliminary report, the effect on thoracic surgery could be profound. It could change thoracoscopy from a tool designed merely for limited diagnosis and for the treatment of pneumothorax and blebs to—who knows? We can hardly wait for the next generation of articles.

The other manuscript, "Basic Approach to Health Screening," by Doctors Swee and Micek-Galinat, is the second part of their evaluation of health screening. They applied basic questions to some of the most common screens: mammography, Papanicolaou (Pap) smears, blood pressure determinations, stool tests for occult blood, sigmoidoscopy, cholesterol levels, and the routine battery of tests often required for hospital admission.

As we noted in an editorial about two years ago, recommendations regarding mammography still are a mixed bag, even though the American Cancer Society and others seem to control public opinion. Likewise, groups disagree on recommendations for the proper frequency for taking Pap smears, and the terminology for reporting has shown major change. What blood pressure should be treated? Do we modify for age? How do we get compliance in both the testing and the treatment? And now,

at what level does pure systolic hypertension warrant treatment? The pitfalls of stool testing for occult blood are well known and well limned by the authors. Their comments concerning current recommendations for sigmoidoscopy, cholesterol testing, and the routine preadmission battery of tests also are cogent.

As Doctors Swee and Micek-Galinat stated, "It is hoped that practicing physicians no longer will give knee-jerk reactions to the variety of national screening recommendations," and they suggest questions for us to ask when such recommendations are made. Call it inquisitiveness, call it curiosity, call it skepticism—it is a necessary quality for the thoughtful physician. Add some imagination and we can change the face and form of medical practice. □ Howard D. Slobodien, MD

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(They taught me all I knew);
Their names are What and Why and When
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Rudyard Kipling, "The Elephant's Child," *Just So Stories,* 1902.

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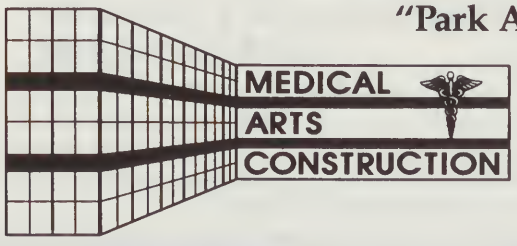
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PRESIDENT 'S PAGE

RBRVS: YOU CAN MAKE A DIFFERENCE

The months of May and June were filled with information, resolutions, debate, guidelines, media interviews, and medical and public concern regarding the serious problem of AIDS in New Jersey and in the United States. Similarly, in August and September much time will be consumed with the inequities reflected in the new proposed Resource-Based Relative Value Scale (RBRVS) methodology announced by the federal government on June 5, 1991. The AMA, MSNJ, county societies, specialty societies, and all grassroots physicians must mount an aggressive campaign to make sure that RBRVS is implemented as it originally was intended.

We are calling upon every physician in America, in an unprecedented letter-writing campaign, to support a rational and fair implementation of the RBRVS system. Following is a copy of the letter sent to all MSNJ physicians:

In 1989, the federal government adopted a phased-in implementation of RBRVS as a payment methodology for physician reimbursement on Medicare. The AMA, after long and arduous debate, cooperated with the federal government and adopted a policy that approved the implementation of RBRVS.

At that time, it was clearly stated that RBRVS implementation would be a "budget neutral" procedure and was not intended as a method of cost control. However, the Health Care Financing Administration (HCFA) has arbitrarily converted RBRVS from a budget-neutral system to a budget-cutting device. On June 5, 1991, HCFA published in the *Federal Register* a Notice of Proposed Rule Making (NPRM) on the Medicare system for reimbursement of physicians' services; this document was different than the one previously accepted.



Joseph A. Riggs, MD

NPRM reflects HCFA's proposed payment schedule on the specialty and state levels, along with associated policy decisions. The proposed payment levels in NPRM reflect a severe 16 percent reduction of the conversion factor (CF). Thus, the federal government is interpreting differently what the appropriate fees should be for physicians' services. By doing so, they broke faith with the AMA and the many physician groups who worked hard to develop a rational, fair way to pay for service under Medicare. They have added a "behavioral adjustment factor" that assumes, without scientific data, all physicians will arbitrarily and capriciously increase their volume of service to compensate for an anticipated decrease in payments for service. This is a breach of promise, and is demeaning and insulting to all physicians.

The proposed reimbursement fee schedule was released by HCFA on June 5, 1991, calling for a 60-day public comment period ending August 5, 1991. The Final Rule is scheduled to be released on October 1, 1991, with implementation to begin January 1, 1992.

In some cases, physician reimbursement will be significantly reduced by as much as 60 percent from previous reimbursement methods. Many procedural fees will be below what "usual and customary" charges were in 1970. Such proposed fees are unfair, disgraceful, outrageous, inappropriate, and unacceptable; and they border on being unconscionable. If implemented, they can have a disastrous effect on the care of not only Medicare recipients, but all other patients as well.

All physicians must take appropriate steps to attempt revisions in the RBRVS reimbursement schedule, and strive for implementation that will reflect reasonable readjustment of physicians' payments and assure that RBRVS is implemented as it was intended. We must prohibit the use of the "behavioral adjustment factor," correct the transition system, and restore a fair and appropriate conversion factor. Even if these requests are granted by Congress, the basic allowance for diagnostic and therapeutic procedures still would be woefully inadequate, and should be corrected at least to previous levels.

The AMA already has complained to the Subcommittee on Health—House Ways and Means Committee—and has received a cynical response to their legiti-

mate expression of concern about access to care for Medicare patients.

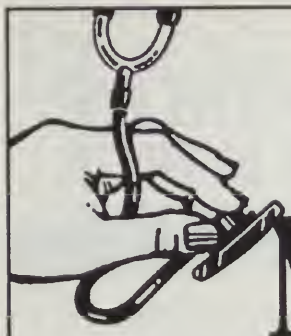
Therefore, we need grassroots communication, cooperation, and activity. The message from grassroots physicians must be heard! There must be unity regarding this issue! We must stand shoulder to shoulder. We need thousands of New Jersey physicians to write letters to the Bush administration, our senators, our congressmen, and federal regulatory agencies. We must make sure that they understand the serious inequities in NPRM, and demand its correction. We also must make them understand that this is the result of specific decisions by HCFA, as well as congressional decisions not to correct these inequities. We must let them know that we—not HCFA—are the architects of our profession and that we always will fight for that right!

Failing appropriate adjustments in the proposed RBRVS payment methodologies for Medicare, we must inform them that the AMA (representing our profession) is prepared to withdraw any previous approval of RBRVS and take appropriate legal and legislative steps to prevent implementation of the proposed scandalous RBRVS payment schedule.

I cannot underscore enough how important it is that you write immediately. Also, please ask your colleagues to write as well, whether they are members of the Medical Society of New Jersey or not. Early reports indicate that there is congressional sympathy with this situation. We must capitalize on this sentiment and have it turned into action to correct what we know is a devastating situation! "Light is the task when many share the load."

You can make a difference! It can mean the survival of the private practice of medicine. □
Joseph A. Riggs, MD

"Together we shall, together we must; God bless!"



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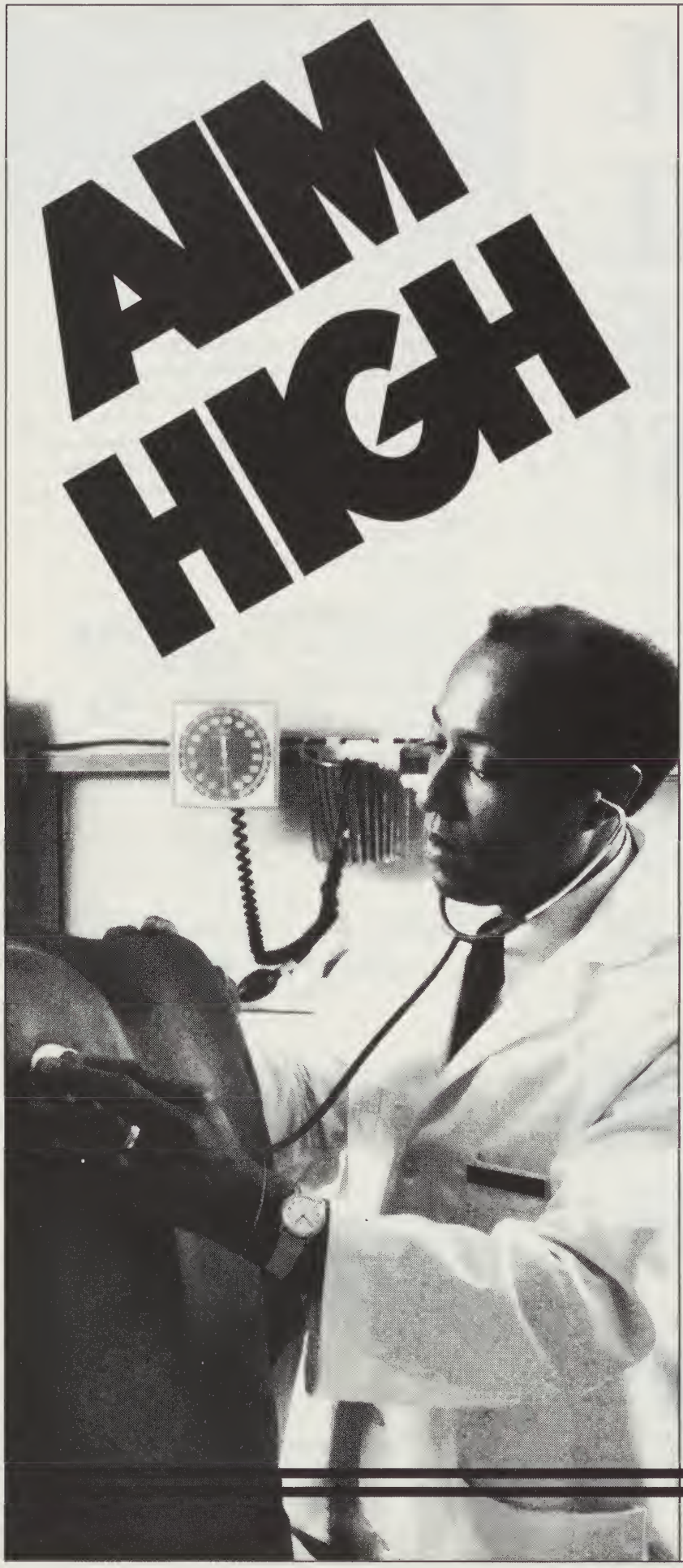
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BOOK REVIEWS

GEL ELECTROPHORESIS OF PROTEINS

BD Hames; D Rickwood. New York, NY, IRL Press, Oxford University Press, 1990. The title of this book—*Gel Electrophoresis of Proteins: A Practical Approach*—is most appropriate. The editors have assembled a group of authors who clearly and comprehensively describe how to perform one- and two-dimensional gel electrophoresis, isoelectric focusing, immunoelectrophoresis, and peptide mapping. Upon finishing this book, the reader will feel capable of performing the various forms of gel electrophoresis since the basic theory, equipment needed, basic methodology, and special modifications for each technique are fully covered. More specifically, there are recipes for the buffers and stock reagents used to make polyacrylamide gels, step-by-step protocols for making different types of gels (slab versus rod, continuous versus discontinuous), and the attributes of the various staining techniques. What makes this book invaluable is the special attention to detail. Also, the authors have included instructions on how to make electrophoresis equipment from scratch.

The same careful thought used for the book's content was used to construct the text. The illustrations are ample and the index is complete. The authors take nothing for granted and even include an appendix of suppliers of specialist items for electrophoresis. The spiral binding allows the book to open easily on the laboratory bench, a real plus when reading the instructions while actually making the gels.

This book would be a welcome addition to the personal library of any researcher interested in learning how to do gel electrophoresis. The book also should be a part of every scientific library of institutions where research in the life sciences is performed. □ Alan H. Wolff, MD

MAMMOGRAPHIC INTERPRETATION

Marc J. Homer. New York, NY, McGraw Hill, 1991. While mammography has become more pervasive in the last few years, good textbooks on the subject are still a rarity. Dr. Marc Homer has committed his famous course to paper, producing an excellent, compact approach to mammographic interpretation entitled, *Mammographic Interpretation: A Practical Approach.*

All aspects of the field are reviewed from the role of the technologist to the pitfalls of the written report. The clinical chapters cover malignant tumors, benign tumors, and the biopsy procedure. The evaluation of carcinomas is subdivided into the detection of localizing signs, e.g. clustered calcifications, and nonlocalizing signs, e.g. skin thickenings. The use of followup examinations to distinguish questionable lesions also is presented.

Dr. Homer describes his techniques for needle localization of masses prior to biopsy. While I found this section informative, even Dr. Homer admits that his technique, without the use of a grid localizer device, is just one technique.

This relatively short text holds much information and is well written. High-quality film screen mammograms are plentiful. This book is highly recommended to the physician who wishes a clear assessment of the field. □ Neil B. Horner, MD

AN OUTLINE OF MODERN PSYCHIATRY

Jennifer Hughes. New York, NY, John Wiley & Sons, 1991. A second edition of this book was issued because of its deserved popularity with medical students and psychiatric residents in Britain. However, it has several disadvantages for use in the United States. The book, *An Outline of Modern Psychiatry, Second Edition,* makes only passing reference to *DSM-III,* and appeared before the current revision *DSM-III-R,* the diagnostic nomenclature used in more recent textbooks. The references given are almost entirely to British publications, with the largest number referring to one journal not readily available in hospital libraries in this country. The medications referred to, unfortunately, often are not marketed in this country, and the proprietary names given of those that are FDA approved are unfamiliar to physicians in the United States. The chapter on legal issues refers entirely to British law.

The book is well written and compact enough to carry in a laboratory coat. It cannot be recommended to physicians or students in the United States. ☐ A. Arthur Sugerman, MD

PATHOLOGY OF THE AGING HUMAN NERVOUS SYSTEM

Serge Duckett, MD. Philadelphia, PA, Lea & Febiger, 1991. This textbook on neuropathology, with emphasis on aging, is a skillfully edited work. Thirty-four contributors from the United States, France, Australia, Canada, Sweden, and Great Britain, are represented, and the writing style has been homogenized, making for ease of reading without the burdens of stilted language and confusion of foreign idioms. The volume is an excellent text of general neuropathology.

The editor points to the increased average longevity from 47 to almost 75 years within this century to emphasize the changing nature of disease distribution and the medical and socioeconomic effects we are experiencing and will continue to see. Genetic, microbiological, chemical, physiological, and epidemiological aspects also are discussed. Chapters on normal aging, nutritional and toxic disorders, dementias, vascular diseases, infections, neoplasms, degenerative afflictions, and immunological disorders also are presented.

Chapters on Alzheimer's, Huntington's, and Parkinson's diseases are especially well written and informative and presented with unusual terse completeness.

By their very nature, textbooks are out-of-date as soon as they are published. But in many instances there has been little new information in the current literature for some of the topics and the included references are reasonably recent. Illustrations including charts, photographs, photomicrographs, electronmicrographs, radiographs, and drawings are laudable and helpful in clarifying the text.

This book can be recommended without hesitation to pathologists, internists, neurologists, neurosurgeons, and other physicians with the need and desire to delve more completely into the effects of aging and the specific disease entities of the nervous system. ☐ Marvin Shuster, MD

BOOK REVIEWS

Book reviews are welcomed by the editor-in-chief. Reviews will be peer reviewed and are subject to editing. Publication will be on a space available basis. Address letters and reviews to Editor-in-Chief, *NEW JERSEY MEDICINE,* Two Princess Road, Lawrenceville, NJ 08648.

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LETTERS AND VIEWPOINTS

MEDICARE EXPENSE FACTORS

Letters to the editor and material circulated by physicians organizing PACs have cited a statistic that, if true, would be a shocking indictment of the federal medical bureaucracy.

I refer to a well-publicized statistic (at least in medical circles) indicating that 70 percent of the Health Care Financing Administration budget goes to administrative costs while only 30 percent of the budget goes to health care providers. If true, it would be clear that the health care financing crisis is the result of an enormous boondoggle diverting necessary health care dollars to administrators and their lackeys, making those funds unavailable to patients in need.

However, in an article, "The Deteriorating Administrative Efficiency of the U.S. Health Care System," published in *The New England Journal of Medicine* (324:1253, 1991). Doctors Woolhandler and Himmelstein, in a well-footnoted and referenced article, indicate that in 1987 the "administrative costs of government health programs such as Medicare and Medicaid" were $6.6 billion out of total expenditures of $207.3 billion, or 3.2 percent. Private insurance companies "skimmed" (my word) 11.9 percent of premiums for administration and profit. Hospital administration represented 20.2 percent of hospital costs.

If these figures are essentially correct (an assumption that seems probable), then our profession is not well-served by the circulation of bloated and insupportable extravagant claims. Those who attempt to induce hysteria by disseminating blatantly erroneous data only undermine the cause they purport to represent, and thereby make it even more difficult to deal with legislators in a responsible fashion, and more difficult to obtain our legitimate goals. ☐ Robert A. Goldstone, MD

Editor's Note. Is it true that the cost of hospitals' and physicians' compliance with governmental regulations is so large that only a portion of it would be needed to provide health care coverage for all the uninsured?

MEDICARE EXPENSE FACTORS: RESPONSE

I have read Doctor Goldstone's letter concerning Medicare expense factors.

I am familiar with *The New England Journal of Medicine* article referenced by Doctor Goldstone. The $6.6 billion he refers to is what the government paid to fiscal intermediaries during 1987. That is not what it costs to deliver $201 billion in payments to providers for their services. It does not account for the salaries, pensions, travel expenses, fringe benefits, heat, power, and lighting costs for operation of the Health Care Financing Administration and other sectors of the Department of Health and Human Services devoted to Medicare. It does not account for monies paid to PRO. It does not account for monies spent by hospitals to comply with the Medicare laws. It does not account for all the expenses related to Medicare administration through the ten regional HCFA offices throughout the country. It does not account for all federal research, councils, and advisory panel costs related to Medicare.

I certainly am convinced that if the total costs of all of this are included, that it certainly does cost $.60-$.70 for every $.40 or $.30 cents paid to Medicare providers. I have not even touched upon the costs that are attributable to Congress related to Medicare.

Frankly, I think if a total cost analysis was done, Doctor Goldstone might find that what is paid to providers is relatively insignificant to what is being spent to operate the Medicare program. ☐ Vincent A. Maressa, Executive Director/General Counsel, MSNJ

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Treating Renal Disease: A History

Sandra W. Moss, MD

As dialysis technology advanced, physicians trained in the new specialty of nephrology set up dialysis programs in hospitals throughout New Jersey. Physicians, state legislators, organizations, and patients contributed to the growth of a life-saving technology.

In the early 1960s, a few patients with renal failure were fortunate enough to be accepted into one of New Jersey's fledgling dialysis programs. With one or two machines, innovative physicians treated acute renal failure and drug overdoses, while training the families of selected patients to perform maintenance home dialysis.

As technology advanced, physicians emerging from early nephrology training programs started dialysis programs in community hospitals throughout New Jersey. The state's first renal transplant was performed in 1968 (Figure 1). A variety of public and private interests contributed to the development of statewide programs for end-stage renal disease (ESRD). This paper will examine the contributions of legislators, bureaucrats, foundations, health care providers, and patients between 1960 and the mid-1970s.

THE RUTH GOTTSCHO FOUNDATION

When Ruth Gottscho, the 15-year-old daughter of Eva Gottscho and the late Ira Gottscho of Millburn (Figures 2 and 3), died of uremia in 1960, chronic hemodialysis was in its earliest experimental stages at a single center in Seattle, Washington. Determined to advance the care of ESRD patients, the Gottschos set up the Ruth Gottscho Kidney Foundation. In 1967, the Foundation began purchasing hemodialysis machines for loan to New Jersey residents for home use. Over the next six years, 181 machines were loaned to a total of 262 patients for as long as each patient required treatment.

The Ruth Gottscho Foundation has been involved in every aspect of ESRD in New Jersey: donating funds for hospital pediatric units, supporting dialysis and transplant programs, funding research, assisting patients, and sponsoring a summer camp program.

THE FORSYTHE BILL

On June 4, 1969, New Jersey Governor Richard Hughes signed into law Senate Bill 769. Sponsored by Senator Edwin For-

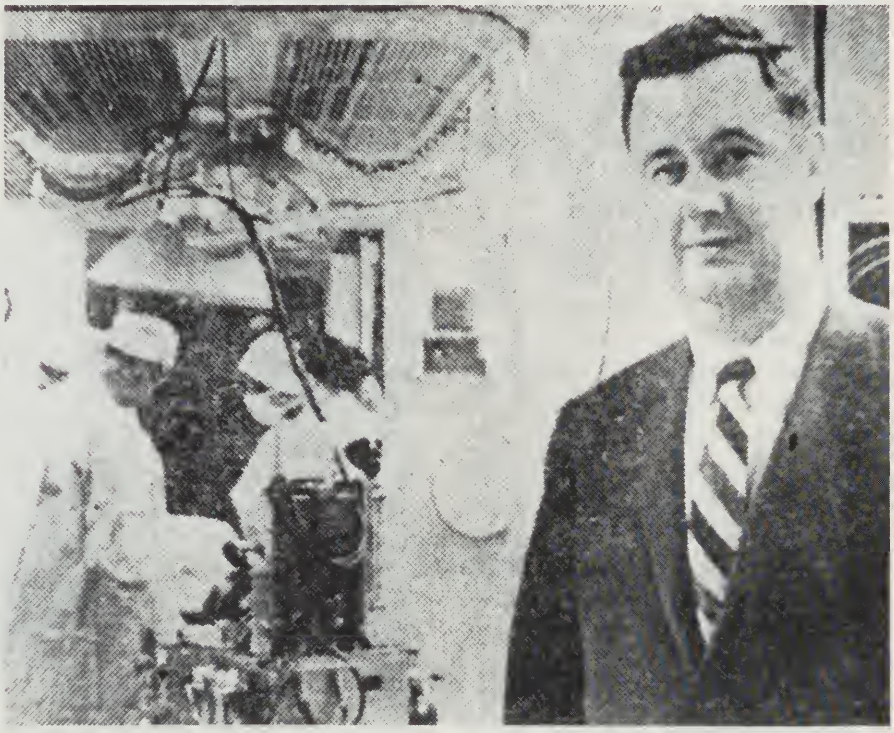


Figure 1. Harold Hardenburg, MD, standing at the door of the hyperbaric chamber at Saint Barnabas Medical Center following the completion of New Jersey's first kidney transplant in 1968. *(Newark Evening News)*

sythe, the bill created the Chronic Renal Disease Program within the New Jersey State Department of Health (NJDOH). New Jersey was one of the first states in the country to pass legislation for ESRD.

It was no coincidence that Governor Hughes took an active interest in New Jersey's renal patients. In 1968, the governor had met the Gottschos and was impressed by their appeal for state assistance. Governor Hughes actively supported the enactment of legislation in the Assembly, encouraging Senator Forsythe to introduce the bill.

Legislation directed that NJDOH develop standards for determining eligibility for treatment of renal patients; aid in development and expansion of treatment programs; assist in developing programs for prevention of chronic renal disease; give financial assistance to chronic renal disease patients; assist in equipping dialysis centers; and promote renal disease education.

At the time the bill was introduced, it was estimated that 59 patients were receiving hemodialysis at eight New Jersey hospitals. This represented less than 10 percent of patients in New Jersey who could benefit from dialysis. Sources of financial assistance prior to the 1969 legislation included some private medical insurance plans, the New Jersey Vocational Rehabilitation Program, local fund drives, and private funds. The state estimated that hemodialysis for patients averaged $10,000 for the first year and $5,000 annually thereafter.[1]

The Assembly appropriated $250,000 for 1969, and further annual appropriations followed. By 1973, funding reached $650,000.[1] Emphasis was on the funding and support of home dialysis. The first recipient of state dialysis funds was a 32-year-old Jersey City man who was granted complete coverage for expenses in August 1969.



Figure 2. Ruth Carol Gottscho died of renal disease in 1960.

CHRONIC RENAL DISEASE ADVISORY COMMITTEE

Legislation mandated the appointment of a Chronic Renal Disease Advisory Committee (CRDAC). Renal physicians, representatives of voluntary and public health agencies, and members of the public served on the 11-member committee. The first chairman, elected in 1969, was Seymour Ribot, MD, of Newark Beth Israel Medical Center. Over the years, virtually every nephrologist in the state served on or chaired CRDAC.

Guided by CRDAC, NJDOH determined eligibility for hospital participation in the program and administered the appropriate funds. Equally important was the key role CRDAC played in the controlled expansion of facilities through its certificate of need review and the drafting of criteria and guidelines for dialysis and transplant programs. In 1979, John Capelli, MD, of Our Lady of Lourdes Hospital, in Camden wrote, "Over the past ten years, CRDAC has been the single most critical element in the design and development of renal services in New Jersey. New Jersey has one of the best designed, appropriately distributed, renal service plans in the country."[1] However, critics of the early certificate of need process maintain that the opening of some new dialysis units was unnecessarily delayed and the growth of dialysis facilities in the state was restricted too rigidly by CRDAC.

In 1972, Ms. Nadeene Brunini (Figure 4), a dynamic woman with 18 years' experience in NJDOH cardiovascular programs, became the coordinator of the state's renal program. Ms. Brunini served as liaison between NJDOH and CRDAC. Her administrative expertise and detailed knowledge made her the focal point of New Jersey's renal program. One New Jersey nephrologist said, "She held the whole thing together."



Figure 3. Eva and Ira Gottscho founded the Ruth Gottscho Kidney Foundation in memory of their daughter.



Figure 4. Ms. Nadeene Brunini was the focal point of the ESRD program.

An extraordinary civil servant, Ms. Brunini, who retired in 1987, earned the respect and praise of New Jersey's renal community.

REGIONAL MEDICAL PROGRAM

In 1969, the Regional Medical Program (RMP) arose out of the United States Public Health Service. Originally a national effort to bring advances in the prevention and treatment of heart disease, cancer, and stroke to the local level, RMP later added a Subcommittee on Hypertension and Renal Disease. Alvin Florin, MD, MPH, was the first coordinator of the New Jersey RMP and Mr. Charles Heitzmann (later executive director of the Academy of Medicine of New Jersey) was associate coordinator. The Subcommittee gathered data and established utilization rates to assist in planning for dialysis and transplantation facilities. RMP worked closely with CRDAC on matters such as certificate of need. Ms. Joan Solanchick succeeded Mr. Heitzmann in 1973. By 1976, RMP was replaced by the administrative structure mandated by Medicare legislation.

PROPRIETARY DIALYSIS UNIT

In 1972, Biomedical Life-Support Systems (BMLSS) applied to NJDOH for a certificate of need for a 20-bed intermediate dialysis facility in Essex county. Mr. Alvin Trenk, chairman of the Board of BMLSS, explained that the intermediate facility would provide chronic dialysis services for stable patients at half the cost of in-hospital units and presented evidence of a need for additional dialysis facilities in the area.[2]

The proposed facility would be owned partly by physicians and operated for profit—a proprietary dialysis unit modeled on a similar facility in Boston. The concept of a physician-owned proprietary dialysis unit was a divisive one in the medical community. The controversy, both in Boston and New Jersey, was deeply felt and slow to resolve. Opposition to the new unit arose not only from its projected impact on nearby hospitals, but also from the physicians opposed to the proprietary nature of the facility.

The RMP subcommittee and CRDAC registered several concerns. Home hemodialysis would become much less attractive to patients, who would opt for the more costly intermediate facility. Nearby hospital dialysis units might lose skilled personnel and patients to the proprietary unit. The state withheld the certificate of need.

BMLSS, convinced that the certificate of need was being wrongly withheld, was granted a hearing by NJDOH in October 1972. The hearing officer, Mr. E. Powers Mincher, was appointed by the commissioner of health. Although nonbinding, his recommendations carried considerable weight. Following the three-day hearing, Mr. Mincher was impressed by statistics that demonstrated a need for new facilities. He gave particular attention to the special needs of people in the Newark area, who often lacked the space and support necessary for home dialysis. He did not think that the new unit would take staff or patients from nearby hospitals.[3] Following Mr. Mincher's strong recommendation, the certificate of need was granted in December 1972; the intermediate dialysis facility opened three months later.

MEDICARE LEGISLATION

At the opening of the 92nd Congress in 1971, the Nixon administration proposed major amendments to the Social Security Act. The House bill, known as HR-1, covered many aspects of health care appropriations. Detailed provisions of the bill were defined by the powerful Ways and Means Committee, headed by Wilbur Mills (D-Arkansas). The Committee heard testimony in favor of appropriations for dialysis and transportation. Organizations such as the National Kidney Foundation strongly supported and lobbied for the legislation. In a grandstand performance that delighted the media, a representative of the National Association of Patients on Hemodialysis was briefly dialyzed in the hearing room before the members of the Ways and Means Committee. In the Senate, Vance Hartke's (D-Indiana) proposal for a kidney disease amendment was quickly approved with virtually no debate or opposition. President Nixon signed the complex health care bill (Public Law 92-603), including the provisions for ESRD (Section 299-1) on October 30, 1972.[4,5]

In essence, Section 299-1 extended Medicare coverage to individuals under 65 years of age if they had ESRD and required dialysis or transplantation. Eligibility began three months after hemodialysis was instituted (acute renal failure was not included in the legislation). Quality of care was a concern, and the legislation limited reimbursement to dialysis and transplant centers that met federal standards determined by the Department of Health,

Education, and Welfare (HEW). Financing was managed by the United States Social Securities Administration.

Although expenditures far outstripped projections and the rehabilitation of patients was not as complete as planners had hoped, the Medicare program made dialysis and transplantation accessible to all Americans. Critics questioned the wisdom of Medicare entitlement for victims of a single illness. Payment for in-center dialysis was a disincentive for less-expensive home dialysis, that some experts considered the best therapy. Others were relieved to see a relaxation of the burden of home dialysis on patients and families. Everybody welcomed the demise of patient selection committees. New Jersey physicians became actively involved in two important issues: the problem of physician reimbursement and the "network controversy."

REIMBURSEMENT

Administrative controversy and bureaucratic delays resulted in reimbursement problems for facilities and patients. Physicians were surprised by interim regulations stating that medical supervision of maintenance dialysis would be considered part of the overhead cost for dialysis. Physicians could negotiate with the facility for reimbursement. Specific fees for physician services would only be made when a complicating medical problem arose during the course of dialysis.[4] Physicians, who previously had been reimbursed by private insurers for uncomplicated dialysis, were quick to respond.

Dr. Capelli, a leading spokesman for the national Renal Physician's Association, advised HEW that direct payment should be made to physicians for supervising and monitoring patients during dialysis. Disagreement between HEW and other federal agencies, as well as the confusion caused by a wide range of proposals for a system of physician reimbursment, caused further delay and frustration. Meetings between HEW and physician's groups in Washington were unrewarding.[4]

In March 1974, New Jersey nephrologists took decisive action and filed suit in United States District Court in Newark against HEW Secretary Weinberger. California nephrologists filed a similar suit. In seeking to win an injunction to halt the proposed Medicare regulations, the suit charged that HEW had unilaterally departed from usual Medicare policies of reimbursement, depriving physicians of just compensation and limiting patient choice of provider. The suit was dropped after HEW proposed an acceptable capitation plan for direct reimbursement of physicians.

STATEWIDE CARE

The Medicare program was to be administered through regional clusters of dialysis and transplant centers called "networks." Each network covered approximately 3.5 million people and included dialysis facilities and two or more transplant facilities. Network administrators and advisory councils concerned themselves with quality assurance, optimal utilization of facilities, coordination of referrals, liaison with other regulatory agencies, gathering and processing of statistics, certification of dialysis and transplant centers, and planning. New Jersey nephrologists, Health Commissioner Ms. Joanne Finlay, the New Jersey College of Medicine and Dentistry, health planning agencies, RMP, and regional HEW consultants recommended that New Jersey comprise a single network. HEW ignored the recommendations, and proposed dividing New Jersey into several networks crossing state lines.

In 1975, there were 16 hospital-affiliated chronic renal disease centers in the state; 8 hospitals had maintenance dialysis intermediate care facilities as well as 1 unaffiliated proprietary intermediate care facility. New Jersey had 3 transplant centers: Newark Beth Israel Medical Center (opened 1968), Newark; Saint Barnabas Medical Center (1973), Livingston; and Our Lady of Lourdes Hospital (1973), Camden. Although patients had no obligation to remain within a network in the course of their care, increasingly large numbers of New Jersey patients utilized local facilities. Established in-state referral systems were desirable. In a letter to the Commissioner of Social Security at HEW, Dr. Capelli wrote: "The Association of Renal Physicians strenuously objects to the arbitrary and capricious manner in which HEW finalized its decision in total disregard for an entire series of recommendations to the contrary."[6] New Jersey's renal facilities had functioned as a unit since the Forsythe bill of 1969.

New Jersey's national congressional delegation strongly supported the designation of a statewide network. Representative James Florio wrote to the Social Security Administration: "A single statewide network would be the most efficient and economical means of planning for manpower requirements and facilities and for insuring the best combination of quality and quantity of these specialized services."[6] The New Jersey medical and political alliance prevailed and on June 3, 1976, the HEW final regulations designated New Jersey as a single network. Dr. Ribot, first chairman of CRDAC, also was the first chairman of the Network's Medical Review Board.

THE DIALYSIS TEAM

The need for trained dialysis nurses became apparent at once. Ms. Carol Passorotti Novembre heard a lecture about dialysis in her senior year at nursing school. In January 1962, she became the first nurse specialist in the renal program directed by Norman Lasker, MD, at the New Jersey College of Medicine, Jersey City



Figure 5. Norman Lasker, MD, and Carol Passorotti Novembre and the prototype peritoneal dialysis cycler he developed in the early 1960s.

(Figure 5). Ms. Novembre quickly became skilled in all aspects of peritoneal dialysis, including the placement of stylet catheters. The first hemodialysis "unit" was a converted kitchen. Ms. Novembre became adept at managing the externalized Scribner shunts that frequently required declotting. For many years, she remained on call 24-hours a day for acute hemodialysis emergencies. Ms. Novembre took an active role in dialysis teaching activities and made house calls for patients on home peritoneal dialysis and hemodialysis.

ONE WOMAN'S ODYSSEY

Mrs. Margaret Maio, a native of Colonia, became progressively uremic in her mid-30s. In 1965, semiconscious and near death, she came by ambulance to Jersey City after hearing of Dr. Lasker's early work with dialysis. Despite the risks and poor prognosis, Mrs. Maio responded well and impressed Dr. Lasker with her determination. Mr. Maio was trained to perform weekly home peritoneal dialysis. Nurse Carol Novembre was involved with Mrs. Maio's care on the day she arrived at the hospital and for many years afterwards.

A local physician came weekly to insert a stylet catheter prior to dialysis. In a converted garage, Mr. Maio and a rotating group of 12 volunteers performed 40 cycles of dialysis each weekend. When insurance funds were depleted, dialysis supplies were purchased with donations. In time, the treatments were accompanied by severe, unrelenting pain during the last few hours of dialysis. Finally, peritoneal inflammation took its toll and Dr. Lasker declared an end to her maintenance peritoneal dialysis after three years.

Mrs. Maio began hemodialysis in 1968. Her husband was trained to perform home hemodialysis. Mrs. Maio became the third recipient of a Ruth Gottscho Foundation dialysis machine. Donations from the Knights of Columbus paid for dialysis supplies for several years. The 1969 Forsythe legislation helped fund the purchase of medication.

In 1976, 11 years after beginning home dialysis and 3 years after passage of the Medicare legislation that covered most of the costs of in-center hemodialysis, Mrs. Maio began to receive her dialysis treatments at Holy Name Hospital, Teaneck. She soon progressed to the hospital's self-care dialysis facility, a unit for patients requiring minimal supervision. Although she thought of Saint Barnabas Medical Center as a "small country hospital," she was impressed with the professional approach of the transplant team, finding it preferable to the impersonal atmosphere she detected at a New York center. In the early 1980s, Mrs. Maio joined a transplant list. Nine months later, a donor kidney became available. She continues to do well six years after receiving her transplant.

CONCLUSION

One should not underestimate the enormous courage and contribution of Margaret Maio and other "pioneer" patients. Her odyssey has been an extraordinary one, spanning 25 years that saw the growth of dialysis in New Jersey from an experimental procedure to routine medical care. During the course of Mrs. Maio's treatment, nephrology became a medical subspecialty. ■

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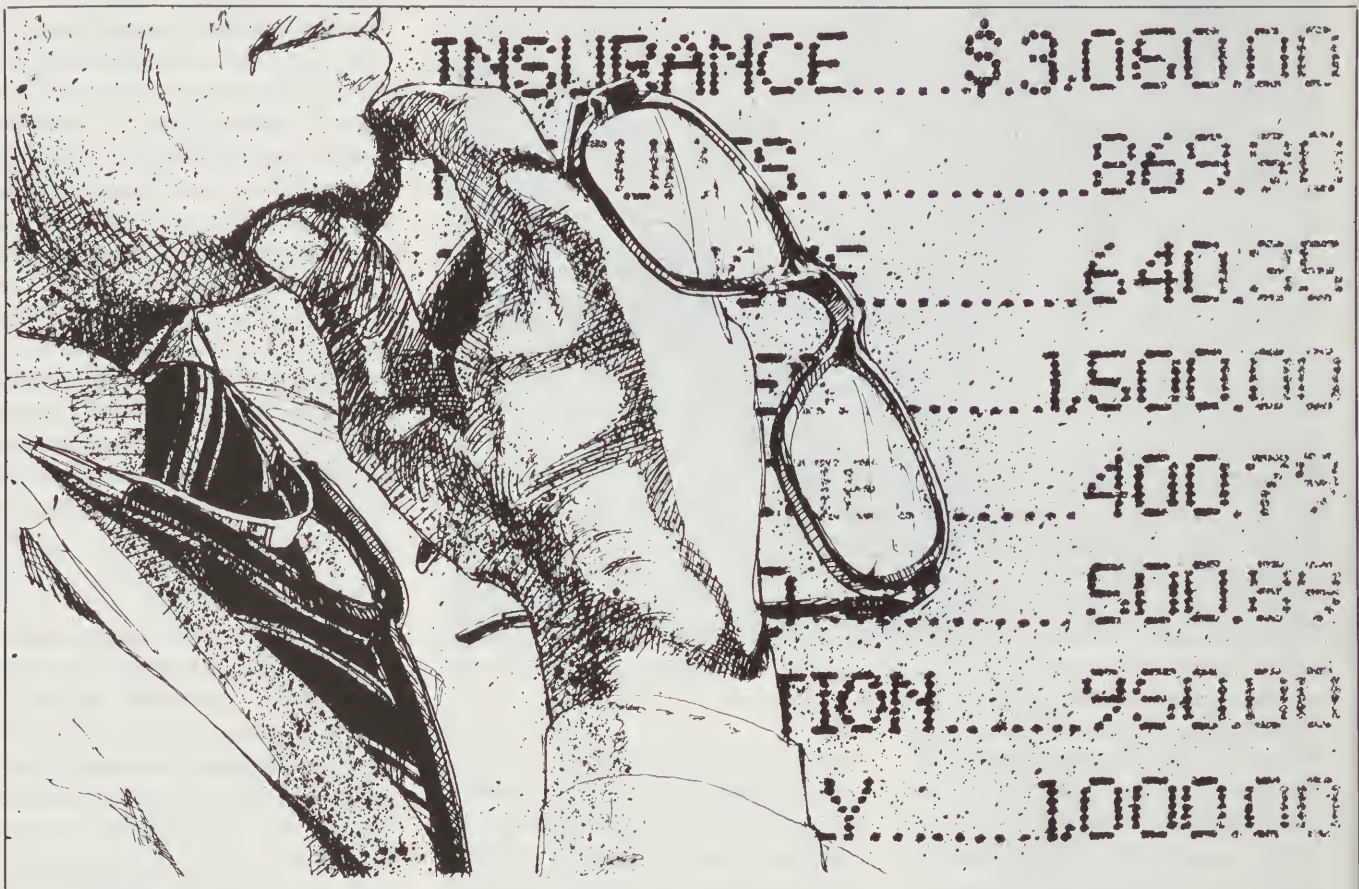
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Dialysis Pioneers of New Jersey

Sandra W. Moss, MD

Dialysis was an experimental procedure when New Jersey's earliest dialysis programs were started by physicians three decades ago. New Jersey's dialysis pioneers recall their early days in a new subspecialty. Patients were fortunate to have such programs available.

Near the end of World War II, Willem Kolff, MD, working secretly in occupied Holland, built a rotating drum artificial kidney. In 1945, a 67-year-old Dutch woman with acute renal failure became the first patient to owe her life to hemodialysis. Dr. Kolff was invited to demonstrate his machine at Mt. Sinai Hospital, New York, where the first dialysis in the United States took place on May 4, 1947. For the next decade, dialysis was confined to a few centers as physicians experimented with improved and innovative dialyzer designs.[1]

In 1956, the Baxter-Travenol company introduced a practical and commercially available dialysis machine. The dialyzer, designed by Dr. Kolff, consisted of two parallel coils of cellophane tubing mounted on a mesh support and wound about a central core (Figure 1). The assembled canister, known as the "twin-coil artificial kidney," was primed with blood and immersed in a 100-liter tank of dialysate (Figure 2). During the course of a single six-hour treatment, the solution in the tank was changed three times. Travenol marketed these machines for $1,200, with each disposable coil dialyzer costing about $60.[1] By 1960, over 100 hospitals across the country had purchased a Travenol dialyzer. At least eight machines had been shipped to New Jersey. However, many hospitals lacked a trained nephrologist to operate the machines and many of these machines went unused.

Because dialysis required access to an artery or central vein, available blood vessels soon were exhausted. Initially, hemodialysis was applicable only to acute renal failure, drug overdoses, and poisonings. In 1960, Belding Scribner, MD, in Seattle, devised an externalized arteriovenous Teflon® shunt that was implanted in the forearm. Despite problems with clotting and infection, the Scribner shunt made chronic hemodialysis possible.



Figure 1. An early Travenol twin-coil dialyzer. (Courtesy Baxter Travenol)



Figure 2. Early Travenol 100-liter tank introduced in 1956.

PIONEERS

The first dialysis programs in New Jersey were started by Seymour Ribot, MD, in Newark, Harold Hardenburg, MD, in Summit, and Norman Lasker, MD, in Jersey City. Dialysis was an innovative procedure at the time, and starting a new program required personal rather than institutional initiative, intellectual curiosity, and a great deal of nerve. "Every dialysis was an experiment," recalled Dr. Lasker. "In those days," remembers Dr. Ribot, "we were all cellophane mechanics."

Overlook Hospital. Dr. Hardenburg (Figure 3) arrived at Overlook Hospital, Summit, in 1960. The Auxiliary had donated a twin-coil artificial kidney to the hospital. CIBA, a nearby pharmaceutical company, was interested in the use of dialysis for acute

drug overdose. Their own product, glutethimide (Doriden®), was a particularly common cause of a fatal drug overdose. Dr. Hardenburg was invited to work with a CIBA research team. The first dialysis subjects were dogs who had undergone ureteral ligation. A uremic dog was anesthetized at CIBA, driven to Overlook Hospital in the back of Dr. Hardenburg's car, transferred to a gurney, covered with a sheet, and rushed through the hospital halls to the dialysis "unit."

Patient dialysis began in 1962. Dr. Hardenburg reported his experience with 28 patients in a 1966 issue of *Journal of Urology:* "Our biggest problem in establishing an active hemodialysis unit was the staff's reluctance to refer patients early enough.... Contrary to the opinion of skeptics, we have clearly demonstrated that extracorporeal hemoalysis can be safely and efficiently performed within the confines of a community hospital."[2]

Dr. Hardenburg's house calls to home dialysis patients combined medical attention to the patient with technical attention to the machine. In the 1960s, he constructed a chronic hemodialysis shunt, but was unable to overcome clotting problems (Figure 4). In 1966, he designed a fail-safe pressure monitor that he installed on existing dialysis machines (Figure 5). In June 1968, Dr. Hardenburg became the nephrologist for the first renal transplant in New Jersey. Dr. Hardenburg continues to pursue research interests in plasmapheresis and cyclosporine pharmacokinetics.



Figure 3. Harold Hardenburg, MD

Newark Beth Israel Medical Center. Dr. Ribot (Figure 6) joined the staff at Newark Beth Israel Medical Center (NBIMC) in the mid-1950s. The Auxiliary had donated a dialysis machine to the hospital some years earlier. Dr. Ribot, whose formal nephrology education consisted of three weeks' training with Dr. Kolff's



Figure 4. The forearm arteriovenous shunt in use during a dialysis treatment.



Figure 5. Overlook Hospital's first dialysis machine, a Travenol 100-liter tank with a twin-coil dialyzer.

group at the Cleveland Clinic, began dialyzing patients in 1958. The hospital administration was less than enthusiastic about this costly (and generally unreimbursed) experimental therapy. Terminally uremic and moribund patients often arrived from distant centers at the hospital emergency room. The machine was kept nearby in a small room shared with the pulmonary function laboratory. Early treatments, complicated by blood pressure and volume shifts, blood clots, and febrile reactions, were characterized by Dr. Ribot as "chaotic."

Martin Jacobs, MD, a native of Newark, was a resident at NBIMC between 1958 and 1961, and later became an attending nephrologist. A few years later, Howard Frankel, MD, joined the house staff and had ample opportunity to work with the hospital's single dialysis machine. Each dialysis, in Dr. Frankel's words, was a "big deal." Dr. Frankel prepared the 100-liter dialysis bath twice in the course of each six-hour dialysis, adding the contents of "three large bottles and three small bottles." When the dialysis was completed, Dr. Frankel scrubbed out the tank. It was not long before a trained nurse took over the dialysis duties under physician supervision (Figure 7).

Each disposable dialysis coil cost a prohibitive $60. A hospital administrator accused Dr. Ribot of bankrupting the hospital. An NBIMC group experimented with an on-site procedure for rolling cellophane tubing. In another effort to reduce costs, the coils were re-used once. Between dialyses, the coils were flushed with saline and chloramphenicol and stored in the blood bank. The blood that remained in the coil at the end of dialysis was saved in collection bottles to prime the coil before the next dialysis.

In 1966, Dr. Ribot reported NBIMC's early experience with chronic hemodialysis.[3] Only one six-hour treatment could be done per day, so a five-day schedule went into effect to accommodate the three patients in the program: "After five months' experience with chronic hemodialysis in a community hospital, we believe that it is feasible. Patients must be selected who are emotionally stable with potential for social rehabilitation. Motivated paramedical personnel can be trained to conduct the dialysis under the supervision of resident or attending staffs so that very little physician time is expended." In the years before federal legislation provided funds for in-center dialysis, virtually all chronic hemodialysis patients were treated at home by a family member who had completed a few months of training in the hospital. Although some families adjusted very well, Dr. Ribot recalls the extreme pressure and stress that devastated other families.

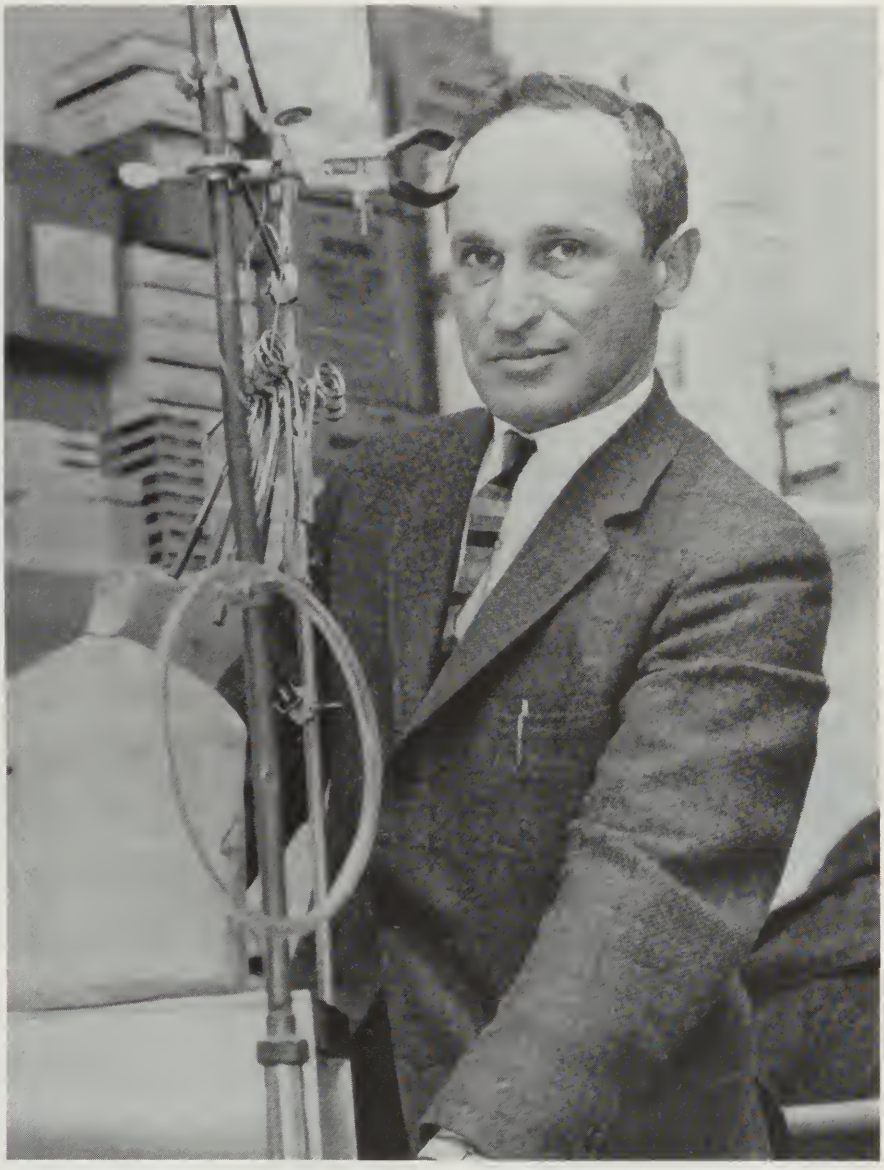


Figure 6. Seymour Ribot, MD, of Newark Beth Israel Medical Center.

By the early 1970s, the NBMIC unit supported a total of 60 patients, many of whom used Kiil dialyzers at home. These dialyzers used parallel sheets of cellophane stretched across a permanent frame (Figure 8). The main advantage was cost (80¢ for four cellophane sheets), but disadvantages included a 12-hour dialysis time and the long frustrating process of assembling the unit for each treatment.

Dr. Jacobs currently is the director of nephrology and transplantation at Saint Barnabas Medical Center.

Upon completing his training,

Dr. Frankel joined the staff of East Orange General Hospital; he is chief of nephrology and hemodialysis. Although dialysis has become routine over the years, Dr. Frankel still recalls the excitement he felt as a resident: "Being able to treat a fatal disease was an exciting new thing."

Dr. Ribot continues as chief of nephrology at NBIMC and has been a dominant force in the growth of nephrology in New Jersey.

Seton Hall College of Medicine. Dr. Lasker (Figure 9), a native of Bayonne, came to Seton Hall College of Medicine in Jersey City as a resident in 1958 and worked with one of New Jersey's first nephrologists, Teruo Takaso, MD. The hospital owned a hemodialysis machine, but Dr. Takaso never had used it. After Dr. Lasker's arrival, the machine was uncrated and both hemodialysis and peritoneal dialysis programs were started.

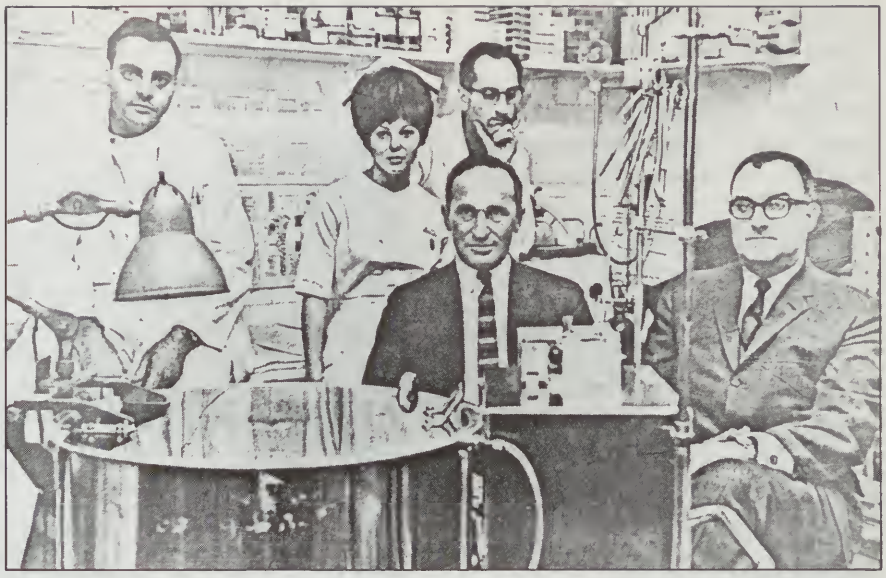


Figure 7. The Newark Beth Israel Medical Center dialysis unit in the early 1960s. From left to right: Howard Frankel, MD, Judith Golden, RN, Seymour Ribot, MD, Martin Jacobs, MD. The physician in the rear is unidentified.

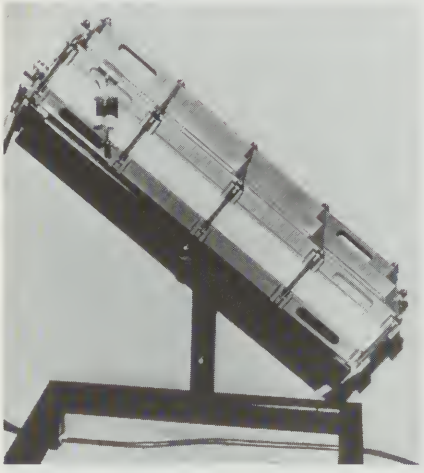


Figure 8. The Kiil parallel plate dialyzer was tedious to assemble, but inexpensive to operate. (Courtesy Baxter Travenol)

In 1964, Dr. Lasker published his experience with chronic peritoneal dialysis.[4] Repeated access to the peritoneum was accomplished with a "Barry" peritoneal cannula, inserted at the bedside. The patients were admitted once weekly for 36 hours of dialysis. The major problem was peritonitis, that developed in virtually all patients and often led to cannula obstruction, omental adhesions, and intestinal obstruction. Dr. Lasker concluded: "In its present stage of development, chronic peritoneal dialysis is not as effective as intermittent prolonged hemodialysis. . . . However, it deserves further investigation in view of its simplicity."

By 1966, Dr. Lasker's experience with chronic peritoneal dialysis was considerable. Patients had been maintained on chronic peritoneal dialysis at home for as long as three years. Lasker was particularly interested in designing a peritoneal dialysis cycler: "It became apparent that an automatic, easily built cycler that allowed the patient and his spouse to get a night of uninterrupted sleep and did not require constant supervision would be of definite value."[4] In 1968, Dr. Lasker moved to Philadelphia, where he perfected a commercially applicable electricomechanical peritoneal dialysis cycler. In 1980, he returned to New Jersey as director of the Division of Nephrology at the University of Medicine and Dentistry, Newark.



Figure 9. Norman Lasker, MD, of New Jersey College of Medicine.

EXPERIMENTAL TO ROUTINE

At the end of the 1960s, the pioneering days of dialysis were over. Newly trained nephrologists were able to purchase efficient, self-contained machines. Hospital administrators welcomed the new units and colleagues understood and appreciated the contributions of dialysis to patient care. Reimbursement issues were addressed on the state level and later by the federal government.

The tedious Kiil dialyzers and ponderous 100-liter tanks that had seen doctors and patients through the early years were replaced with machines such as Travenol's recirculating single pass machine that became available in 1968 (Figure 10). The twin-coil dialyzers were modified and improved and hollow fiber

dialyzers were introduced to the physician population.

The Scribner shunt was complicated by infection and clotting. One particularly catastrophic complication was the loosening of the cannula from the artery. One New Jersey nephrologist, by chance, was riding in an elevator with a patient when her shunt suddenly loosened. Controlling the exsanguinating arterial hemorrhage with digital pressure, he located a hospital surgeon, and maintained hemostasis until the vessel could be clamped. A colleague characterized the shunts as "a terrible mess."

At the Bronx Veterans Administration Hospital, James Cimino, MD, had an elegantly simple idea: if a small arteriovenous fistula could be created between the radial artery and a vein, the forearm veins would become hypertrophied. Repeated percutaneous venipuncture with large bore needles would provide blood flow sufficient for hemodialysis. Dr. Cimino and his colleagues, with the assistance of chief technician Mr. Reuben Aboody, constructed the first fistula in 1965. Nephrologists adopted the procedure. Both Dr. Cimino and Mr. Aboody joined the New Jersey dialysis community through their association with Holy Name Hospital, Teaneck.

The second wave of New Jersey nephrologists set up new programs statewide. Most programs began with only one or two machines. Mark Needle, MD, of Saint Joseph's Hospital, Paterson, remembers: "We started with one doctor, one nurse, one machine, and one patient." Dr. Needle became the first president of the New Jersey Society of Nephrology in 1973.

Northern New Jersey. Robert Rigolosi, MD, a native of Garfield, established a dialysis program at Teaneck's Holy Name Hospital in 1969. Although the usual dialysis guidelines suggested age criteria of 15 to 55 years, Dr. Rigolosi and the hospital's dialysis committee ignored the guidelines and began the program with a 14-year-old boy with hereditary nephritis and a 65-year-old man. Among those treated in the early years was a chief justice of the New Jersey Supreme Court.

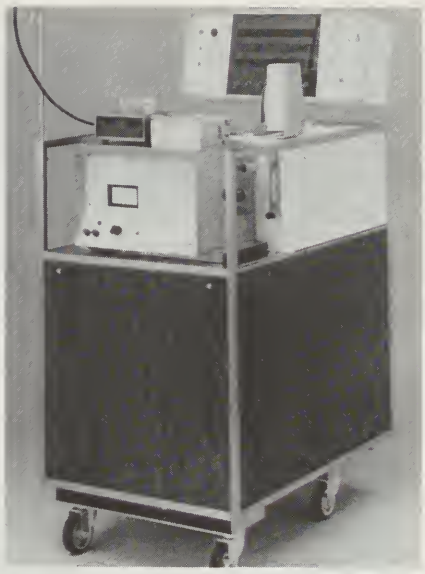


Figure 10. The Recirculating Single Pass (RSP) dialyzer popular in the 1970s. (Courtesy Baxter Travenol)

William C. Black, MD, has practiced nephrology in his hometown of Hackensack since 1964. The first patient was dialyzed in 1967, and a small unit, among the first in New Jersey, was functioning by 1971. The aura of kitchen chemistry that accompanied the preparation of a dialysis bath in those early days was further enhanced by the use of a long-handled wooden spoon to stir the solution.

Richard Wedeen, MD, became chief of the renal service at Jersey City Medical Center in 1971. In 1977, he wrote: "Our hospital serves the urban outcasts, the underskilled, undereducated, and sometimes sociopathic dropouts of urban civilization. . . . Most of our dialysis patients have neither the basic educational background nor the cohesive family structure to motivate home dialysis. These are the people who have fallen between the cracks of our society for generations. But to deny them access to life-saving hemodialysis therapy because of their inability to cope with the sophisticated demands of home dialysis would be appallingly discriminatory." Dr. Wedeen currently heads the Division of Occupational and Environmental Medicine at UMDNJ, Newark.

Anthony King, MD, came to the East Orange Veterans Administration Medical Center in the mid-1960s. Dr. King was strong-willed, opinionated, and tenaciously devoted to his renal patients. His former colleagues remember his flamboyant personality, bulldog-like enthusiasm, cordial disregard for regulations, and the polished 19th century gentlemanly speech that contrasted with a rather informal personal style. Long after he was terminally ill, Dr. King continued to care for his patients.

Central New Jersey. Anthony Donatelli, MD, trained with Dr. Lasker in Jersey City and joined the staff of Muhlenberg Hospital, Plainfield, in 1965. The hospital owned one dialysis machine, purchased in memory of a patient who had died of uremia. The unit grew; 30 patients were trained for home dialysis. Satu Mitrakul, MD, joined Dr. Donatelli in 1971. The workhorse Travenol RSP dialyzers were used until the mid-1970s and then the machines were sold to hospitals in Chile.

LeRoy Homer, MD, joined the staff at Perth Amboy General Hospital in 1954 as an internist. Some years later, a dialysis machine was donated to the hospital. Dr. Homer found the prospect of performing hemodialysis appealing. In 1970, he completed a practical two-week dialysis course at NBIMC and then set up a dialysis program in Perth Amboy. In recent years, Dr. Homer has had the unusual pleasure of sharing his nephrology practice with one of his sons.

Robert Dodelson, MD, came to St. Peter's Hospital and Middlesex General Hospital, New Brunswick, in 1967. Dr. Dodelson immediately began performing acute peritoneal dialysis; but neither hospital was interested in his proposal for an acute hemodialysis program.

In 1973, Robert Eisinger, MD, former chief of nephrology at the Manhattan Veterans Administration Hospital, became chief of nephrology at the new Rutgers Medical School. He started a two-bed hemodialysis unit at Raritan Valley Hospital, Green Brook, the school's first teaching hospital.

Southern New Jersey. John Capelli, MD, a native of Hammonton, came to Our Lady of Lourdes Hospital, Camden, in 1969. His first two machines were housed in a building formerly occupied by a Studebaker dealership. Dr. Capelli and two nurses wheeled the machine across the street and set up shop in the patient's room. Because his program was new, and nearby Philadelphia was attractive to many people in the area, Dr. Capelli's first few patients were either nonpaying or desperately ill. He realized his goal of a comprehensive end-stage renal program at Our Lady of Lourdes in 1973, when the state approved renal transplantation. Dr. Capelli has been a spokesman for New Jersey's renal physicians both on the state and national levels.

John Mele, MD, had a personal interest in renal disease. While he was in medical school, his sister died of uremia at a time when there was no effective therapy for end-stage renal disease. Dr. Mele came to Jersey Shore Medical Center, Neptune, in 1961 and started the dialysis program some years later. The first two machines were purchased with a donation from a patient active in the political arena. Dr. Mele visited organizations such as veteran's groups to help raise funds. His handwritten notes to these organizations were particularly effective fundraisers, reflecting both his sincerity and his lack of money for a secretary. In time, the hospital trained 50 to 60 home hemodialysis patients. In 1969, he reported his experience with 23 patients in *The Journal of the Medical Society of New Jersey.*[6] In 1970, Franklin Scudder, MD, a native of Jersey City, set up a dialysis program at Shore Memorial Hospital, Somers Point.

James Greco, MD, a native of Union City, was a dentist before becoming a nephrologist. Arriving at Monmouth Medical Center, Long Branch, 1971, Dr. Greco found that the sole dialysis machine was caked with oil from an early attempt at lipid dialysis for glutethimide overdose. The machine was cleaned and used until new technology replaced it. Monmouth Medical Center's first dialysis machine retired in style, ending its professional life as a champagne cooler at a dialysis unit party.

CONCLUSION

New Jersey had great fortune with the physicians who pioneered the treatment of acute and chronic renal failure in the state. Many nephrologists recall their early years in dialysis as "fun" and professionally satisfying, pointing out that hospitals today would not permit such free rein for unapproved and innovative therapies. All were relieved when federal financing made dialysis an option for every patient, not only those judged suitable by a committee. At the same time, the intensely close relationship formed by each physician with his earliest patients became a thing of the past. One nephrologist, reflecting on his early years in practice, said: "We lived and died with those people." ■

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Tissue Plasminogen Activator: Hospital Experience

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Tissue plasminogen activator (t-PA) is administered safely and efficiently in the treatment of acute myocardial infarction (MI). A study of 74 patients administered t-PA for acute MI associated with a low complication rate showed an acceptable patency rate, and a good outcome.

Over the past several years, many changes have occurred in the management of acute myocardial infarction (MI), most notably the development of thrombolytic therapy. With over 80 percent of acute coronary occlusions thrombotic in nature,[1] agents and methods to dissolve the clot have evolved as an effective way to preserve myocardium and to reduce mortality during acute MI. Initial experience was gained in university hospital settings but with time the use of thrombolytic therapy became widespread in community hospitals.[2,3]

Early reports discussed the use of intravenous streptokinase as a thrombolytic agent; enthusiasm developed for the intracoronary administration of this agent.[4] However, because this approach is impractical in most clinical settings, especially in community hospitals, and the recognition that this method may delay time to clot lysis, thus, counteracting the advantage of direct intracoronary infusion, this approach rarely is utilized. The Gruppo Italiano per lo Studio della Streptochinasi nell'Infarto Miocardico (GISSI-1) Trial in 1986 of 11,806 acute MI patients demonstrated the effectiveness of intravenous streptokinase in reducing mortality by 18 percent and emphasized the importance of early intervention by showing a 47 percent mortality reduction in patients treated during the first hour after onset of symptoms.[5]

In the meantime, enthusiastic reports were claiming the superiority of another clot lysing substance, tissue plasminogen activator (t-PA). Ultimately, the report of Thrombolysis in Myocardial Infarction (TIMI-I) Trial indicated an almost twice greater efficacy of t-PA over streptokinase in opening initially closed coronary arteries.[6] Therefore, clinical availability of this agent was awaited anxiously by cardiologists and the patients of community hospitals. Following its approval by the Food and Drug Administration in November 1987, t-PA was immediately introduced for early management of acute MI at Overlook Hospital.

We report the first 12 months of experience with t-PA in the management of acute MI and describe the potential for thrombolytic therapy in the spectrum of MI in a New Jersey community hospital.

SUBJECTS AND METHODS

We reviewed electrocardiograms (ECGs) for all patients with a final diagnosis of acute MI at Overlook Hospital from January 1, 1988, through December 31, 1988. We reviewed the charts of the patients with ECG changes qualifying them for thrombolytic therapy to assess the reasons they did not receive such therapy. In addition, data were obtained on all patients receiving thrombolytic agents.

Patients received thrombolytic therapy according to a standard protocol developed by a panel of cardiologists and the clinical nurse specialist. The decision to treat, including the choice of streptokinase or t-PA as the thrombolytic agent, was made by the consulting cardiologist present at the bedside. Cardiologists were encouraged to choose streptokinase if the drug could be administered within two hours after onset of symptoms. Criteria for use of the thrombolytic agent included: chest pain less than six hours in duration since onset, unrelieved by nitroglycerin, associated with ST segment elevation 1.5 mm or more in two or more frontal plane leads, or 2 mm or more in two or more contiguous chest leads. Contraindications included: history of recent stroke, recent surgery, prolonged cardiopulmonary resuscitation, recent gastrointestinal bleed, bleeding disorders, vascular puncture in a noncompressable site, and severe uncontrolled

hypertension. Relative contraindications were age greater than 75 years and onset of symptoms to time of treatment greater than six hours. Treatment was begun in the emergency department or the critical care unit, although initiation in any patient unit was permitted with immediate transfer to a critical care unit. Use of additional therapeutic agents was left to the discretion of the attending cardiologist.

Coronary arteriography was performed in the majority of the patients receiving thrombolytic therapy in accordance with the standard of practice common in 1988 and before the results of the TIMI-IIB Trial were available.[7]

RESULTS

During the study period, 384 patients were treated for acute MI and, of these, 118 patients had ECG criteria qualifying them for thrombolytic therapy. Among these, 71 patients were treated with t-PA and 3 patients were treated with streptokinase. An additional 3 patients received t-PA in whom it was later determined that the presenting symptoms were not due to coronary artery disease. Forty-four patients with qualifying ECG criteria were excluded from thrombolytic therapy because of: age greater than 75 years in 19 patients; greater than six hours from symptom onset in 10 patients; active bleeding in 3 patients; prolonged cardiopulmonary resuscitation in 2 patients; recent MI in 2 patients; uncontrolled hypertension in 1 patient; recent central line placement in 3 patients; resolution of chest pain after nitroglycerin in 2 patients; and reasons not clear in 2 patients.

Characteristics of patients receiving t-PA were as follows: 82 percent were men; median age was 60 years (30 to 79 years); and location of infarct: inferior in 36 patients, inferolateral in 7 patients, inferoposterior in 5 patients, inferoposterolateral in 1 patient, posterolateral in 1 patient, anteroseptal in 20 patients, anterolateral in 2 patients, and anteroseptal and lateral in 2 patients. The time of onset of symptoms to treatment ranged from 20 minutes to 600 minutes with a median of 150 minutes. The time from arrival in the hospital to treatment ranged from 15 to 180 minutes, with a median of 65 minutes. Seven patients received treatment within 60 minutes of symptom onset and 26 patients received treatment within 120 minutes of symptom onset. Approximately half of the treated patients presenting in the emergency department were transported there by the mobile intensive care unit.

Hospital mortality was 5.6 percent for patients with t-PA; 9.8 percent for patients age 75 or less, and 23 percent for patients over age 75. Complications in patients receiving t-PA included 1 retroperitoneal bleed requiring blood transfusion (1 unit); a minor retinal bleed with no permanent sequela; and a case of renal failure, possibly secondary to embolization from a mural thrombus. There were no cerebrovascular accidents.

Angiography was performed in 64 patients two to seven days after t-PA treatment with the following findings in the infarct related vessel: 100 percent occlusion in 12 patients (7 patients with right coronary, 1 patient with circumflex, and 4 patients with anterior descending artery), 90 to 99 percent narrowing in 39 patients, 70 to 89 percent narrowing in 10 patients, 50 to 69 percent narrowing in 1 patient, less than 50 percent narrowing in 2 patients, and unknown narrowing in 2 patients. Posthospital management was medical in 15 patients, referral for bypass surgery in 16 patients, and angioplasty in 35 patients.

COMMENTS

Our findings concerning the use of thrombolytic therapy in acute MI patients confirms the experience of many investigators, that a relatively small percentage of such patients are candidates for thrombolytic agents using currently accepted guidelines. Experience (Table) indicates that only 9 to 19 percent of infarct patients actually receive this treatment.[8-11] Eisenberg et al. indicate that up to 26 percent of patients could have received therapy using "restrictive" criteria.[8] While our experience and that of Lee et al.[9] and of Eisenberg et al.[8] showed that lack of ECG criteria for acute infarction was the most frequent reason for exclusion (average 69 percent), Murray et al.[10] and Cragg et al.[11] reported this to be the case much less often (21 percent and 27 percent, respectively). Furthermore, it would appear that approximately 19 to 27 percent of patients presenting with acute MI are over age 75, while up to 58 percent cannot be treated in less than 6 hours after onset of symptoms. In the GISSI-1 Trial, 21 percent of those patients randomized were over age 75 and over 10,000 patients suspected of acute MI were excluded because of onset of symptoms more than 12 hours prior to possible treatment.

In order to expose larger numbers of infarct patients to the potential benefit of thrombolytic therapy, it would be necessary to consider including patients over the age of 75, those without currently accepted ECG injury patterns, and/or those presenting outside the therapeutic window.

The authors stress the need to reduce treatment delay time resulting from patient inaction and system inefficiencies after a New Jersey community hospital study of 74 patients.

Table. *Reasons for excluding thrombolytic therapy in acute myocardial infarction.*

Study	Murray et al.[10]	Cragg et al.[11]	Lee et al.[9]	LiMandri et al.	Eisenberg et al.[8]
ECG not qualifying	84 (21%)	323 (27%)	657 (59%)	266 (69%)	797 (79%)
Contraindication	45	99	–	11*	462 (43%)
Late presentation	157 (39%)	186 (15%)	403 (36%)	10*	627 (58%)
Atypical symptoms	19	–	–	2*	–
Age >70[9] or >75	42	324 (27%)	210 (19%)	19*	269 (25%)
Other reasons	20	111	–	2*	–
Eligible for thrombolysis	36 (9%)	163 (14%)	261**(23%)	74 (19%)	280 (26%)
Total number of patients	403	1206	1118	384	1076

*Figures apply only to patients with a qualifying ECG.
**Age 75 or younger presenting with qualifying ECG within 4 hours of onset of symptoms; includes those with contraindications. Author estimates only 12 to 17 percent would have been eligible for therapy.

With regard to the elderly, we found a hospital mortality rate of 23 percent among 118 elderly patients over age 75 and it previously has been reported that nearly 50 percent of all deaths in hospitalized patients with MI occur in this age group.[12] Unfortunately, since most large trials conducted to date excluded patients over age 75, the question of whether the benefit of thrombolytic therapy in these elderly patients outweighs the risks has not been resolved. Only in the GISSI Trial were elderly patients enrolled; and they reported a 13 percent reduction in mortality at three weeks in those over age 75, but this was not statistically significant. The incidence of bleeding complications in this treated group was apparently similar to the placebo group. In a report from the TIMI-I Trial where patients over age 75 were excluded, the hospital mortality increased significantly with age and was 3.5 percent, 11.5 percent, and 12 percent in patients less than 65 years of age, 65 to 69 years of age, and 70 to 76 years of age, respectively.[13] However, the incidence of major bleeding events among patients not undergoing heart surgery also increased significantly with age and was 8.7 percent, 14.5 percent, and 24.7 percent, respectively, in these three groups. On the other hand, in the second International Study of Infarct Survival (ISIS-II) Trial, there was no excess bleeding noted among 3,411 patients age 70 years and older.[14] It is not clear from their report how many patients were over age 75. In our series, 3 patients over age 75 received t-PA while 19 patients over age 75 and with qualifying ECG criteria were excluded because of age. It should be noted that only 22 of 118 patients (18.6 percent) over age 75 had a qualifying ECG criteria compared to 36.8 percent in those under age 76. We believe that patients over age 75 who present early with large areas of myocardium at risk or who are otherwise at high risk should be strongly considered for thrombolytic therapy after careful search to exclude those at high risk of bleeding. While it is tempting to expand inclusion criteria by considering less specific ECG changes in patients with chest pain suggestive of MI, there should be concern for the potential of unnecessary risk and cost. Thought should be given to identification of subsets of patients who have large infarcts since they seem to benefit most. In this regard, patients with characteristic chest pain and new onset left bundle branch block should be strongly considered since they probably are in the midst of a large anteroseptal infarction. It is not clear what to do in patients with ST or T wave inversion since these findings are not specific for acute MI. Early detection of MI by analysis for isoforms of creatine kinase isoenzymes may allow better selection of such patients in the future.[15] At this time, however, continued use of the current ECG guidelines seems appropriate.

Although the use of thrombolytic therapy for strictly inferior infarction is somewhat controversial because of the good prognosis without thrombolytic therapy in these cases, we found a moderately high incidence (37 percent) of inferior infarcts in our series. In addition, 18 percent of our patients had large inferior infarcts (inferolateral or inferoposterior in location). Data from GISSI-1[5] and ISIS-II[14] Trials suggest a benefit from treatment of large inferior infarcts and in smaller inferior infarcts that can be treated within the first three hours after onset of symptoms. As was reviewed by Bates,[16] those presenting with prominent inferior injury patterns and/or showing precordial ST segment depression have large infarcts and should be treated. In other cases of inferior infarction where the prognosis is good, careful analysis

of risk versus benefit of thrombolytic therapy should guide treatment.

The final area to be considered in possible expansion of indications is related to the "therapeutic window." In our series, only 4 patients received t-PA after 6 hours from onset of symptoms, in each case because of continuing chest pain. While in the GISSI-1 Trial, there was no mortality difference between placebo and treatment among 1,946 patients treated more than 6 hours after symptom onset, a statistically significant reduction in mortality was reported by ISIS-II Trial among the large number of patients treated 6 to 24 hours after onset of symptoms. Although the mechanism of benefit in this late-treated group is not clear, it has been suggested that survival in some way is linked to achieving and maintaining patency of the infarct related artery.[17] Currently, we consider late administration of thrombolytic agents predominantly when there is presence of ongoing or recurrent ischemic pain. Our median time from onset of symptoms to treatment was 150 minutes, mainly due to patient delay in entering the emergency system after onset of symptoms. We consider it extremely important to continue efforts to educate our community about the advantages of early treatment of MI with thrombolytic agents. The second delay point occurred in the hospital as seen by our range of delay after arrival of 15 to 180 minutes (median 65 minutes). As one approach to this problem, we have introduced transmission of the 12-lead ECG from the field by mobile intensive care personnel in chest pain cases in order to allow earlier diagnosis of acute MI and, therefore, earlier thrombolytic therapy. We still require the attending cardiologist to be present to authorize and initiate thrombolytic therapy when appropriate in suspected cases of MI. In association with this policy, 3 of 77 patients (3.8 percent) were treated for suspected MI in whom the final diagnoses were myocarditis, pericarditis, and musculoskeletal pain associated with ST elevation due to early repolarization. In the TIMI-II Trial, the "error" rate was similarly 5 percent. Topol et al. reported a 5.6 percent incidence of misdiagnosis in a community hospital experience with t-PA administration.[3]

Although there is a wide difference in cost among available thrombolytic agents, we have not commented on the selection of a specific agent for use in acute MI since it is not yet clear what agent or regimen is most ideal. The GISSI-2 Trial showed no difference in hospital mortality in acute MI between two groups treated with either streptokinase or t-PA with or without subsequent heparin therapy administered subcutaneously 12 hours after initiation of thrombolytic therapy.[18] Some have argued that this late administration of heparin biased the study against t-PA that has a short half life and usually is administered with concomitant intravenous heparin therapy carefully controlled. In fact, the recently reported heparin-aspirin reperfusion trial showed a 82 percent reperfusion rate for patients receiving intravenous heparin immediately following t-PA administration compared to a 52 percent reperfusion rate for those patients receiving only aspirin following t-PA in acute MI.[19] ISIS-III Trial is comparing streptokinase, t-PA, and eminase, and a new trial, Global Utilization of Streptokinase and t-PA (GUSTO), is comparing streptokinase, t-PA alone, and t-PA with streptokinase all with concomitant intravenous heparin therapy as currently is the practice in the United States. While an answer may be forthcoming regarding the best thrombolytic regimen as a result of these various studies, we believe the more important question is how to accomplish earlier administration of any of these agents to the widest spectrum of acute MI patients that is appropriate. While cost consideration is important, it should not supercede efficacy when selecting thrombolytic regimens.

SUMMARY

We report a community hospital experience with t-PA administration for acute MI associated with a low complication rate, acceptable patency rate (78 percent at two to seven days postinfarction), and good outcome (hospital mortality 5.6 percent). We emphasize the point that, using current guidelines, only 10 to 19 percent of patients are receiving thrombolytic therapy for MI and discuss areas where inclusion criteria might be expanded, particularly among the elderly where standard mortality rates are quite high. Finally, we reiterate the need to reduce treatment delay time resulting from patient inaction and system inefficiencies. ■

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Advances in Neurology at Turner's Lane Military Hospital

Stephen M. Salerno

The work of physicians at Turner's Lane Military Hospital, Philadelphia, stimulated interest in neurology in the United States, leading to the post-Civil War emergence of neurology as a distinct medical specialty. These physicians advanced their profession and benefitted their patients.

The research conducted by Silas Weir Mitchell, George R. Morehouse, and William W. Keen at Turner's Lane Military Hospital during the Civil War made an important contribution to medical knowledge of traumatic injuries of peripheral nerves. Their major work, *Gunshot Wounds and Other Injuries of Nerves*, gives an eloquent description of the results of peripheral nerve injuries as well as describing progressive therapies used to treat them. Although some treatments used at Turner's Lane such as faradization no longer are in use, many diagnostic descriptions and therapy concepts still are relevant today. The work of the Turner's Lane physicians stimulated interest in neurology in the United States leading to the postwar emergence of neurology as a distinct medical specialty.

Except for the documentation of sporadic cases, little research had been done on peripheral nerve trauma and treatment. Nerve cases generally were viewed as curiosities with little hope for recovery. As Charles Bell said in 1822: "The endless confusion of the subject [the nervous system] induces the physician, instead of taking the nervous system as the secure ground of his practice to dismiss it from his course of study as a subject presenting too great irregularity for legitimate investigation or reliance."[1] The work at Turner's Lane was to change this and make the diagnosis and treatment of peripheral nerve injuries a reality.

Interestingly, none of the Turner's Lane team had significant experience in neurology before the war. Of the doctors working at the Turner's Lane Hospital, none surpassed Silas Weir Mitchell, the father of American neurology. Mitchell was a brilliant neurologist, respected physiologist, and successful novelist and poet.

Although Mitchell achieved great success later in life, he was an obscure Philadelphia physician practicing general medicine before the Civil War. He had a variety of research interests and published extensively. One of his partners in research on venom toxicology was William A. Hammond, who later became United States Army Surgeon General during the Civil War.[2]

After war broke out, Mitchell worked at the Filbert Street Army Hospital in Philadelphia in 1862, where he became interested in nerve injuries. Mitchell's research on nerves attracted the interest of Surgeon General Hammond, who set up a small hospital on Christian Street exclusively for nerve injuries. Mitchell asked a former classmate at Jefferson, Dr. George Morehouse, to assist him at the new hospital.

Morehouse was less prolific a researcher than Mitchell, preferring to devote his time to his large private practice.[3] The last member of the medical team, William W. Keen, was the least seasoned. Later achieving fame as a neurosurgeon, Keen described himself as a "mere medical kid" at the time of the Civil War.[4] A graduate of Jefferson, Keen proved his worth to Mitchell years earlier as a medical student assisting the doctor in venom research. Before his transfer to Christian Street at the request of Mitchell, Keen served as a field surgeon for the Union army. As the junior member of the trio, Keen lived and worked as the resident at Turner's Lane.[3]

The neurology ward at Christian Street became overfilled rapidly as referrals poured in across the north. Consequently, Hammond decided to establish a 400-bed hospital at Turner's Lane devoted exclusively to nerve injuries with the exception of a small cardiac ward under the direction of a Dr. De Costa, another of Mitchell's close friends.[5] The surgeon general also

relieved the neurological team of many routine duties and red tape by special order. Mitchell acknowledged these favors and praised Hammond in the preface of the book compiled from the war research.[6]

Civil War hospitals such as Turner's Lane were not aseptic, but were a big improvement from the fetid facilities used during the Crimean War. Popular medical theory postulated that morbidity in hospitals was proportional to the number of patients due to the concentration of an elusive poison.[7] Surgeon General Hammond based the construction of his hospitals, including Turner's Lane, on the pavillion model. This type of hospital had low long wings (pavillions) branching out from a central building or corridor. This was believed to segregate hospital poisons and provide better management of wards.[7]

The layout of Turner's Lane Hospital was similar to other hospitals of the pavillion type built during that period. Contemporary descriptions are limited, but several photographs show the hospital's layout. Mitchell describes the hospital as "a pleasant old-fashioned country seat, its gardens surrounded by a circle of wooden one-story wards, shaded by pine trees."[3]

Life at Turner's Lane probably did not differ from other Army hospitals at the time. At military hospitals, discipline was strictly enforced and patients were expected to rise to attention and salute when a commissioned officer, even a surgeon, entered the room. Patients well enough were expected to do chores.[4,7]

Mitchell's writing reveals his team's daily routine. Morehouse and Mitchell kept their private practices while working at the hospital. They visited the hospital at 7 A.M., and performed rounds with Keen who lived at the hospital. Then Mitchell and Morehouse left to attend to their practices. Mitchell and Morehouse met at the hospital at 3 P.M. and conducted examinations and note taking until midnight. Their nights at the hospital sometimes would last longer if a battle brought new cases to the hospital.[8] After work, Mitchell and Morehouse walked home discussing cases. Mitchell wrote, "I have worked with many men since, but never with any who took more delight in repaying opportunity by labor. . . . I sometimes wonder how we stood it."[9]

Work continued in this fashion until 1864. Most of the important advances at the hospital ended then as Mitchell took a leave of absence to go to Europe. He resigned from government service shortly thereafter for personal reasons. Nevertheless, before the neurological team parted, they published their main work, *Gunshot Wounds and Other Injuries of Nerves*, in 1864.

Gunshot Wounds and Other Injuries of Nerves is organized into 11 chapters dealing with general descriptions of the diagnosis and treatment of peripheral nerve injuries and detailed accounts of injuries of specific nerves such as the facial nerve and the trigeminal nerve.

After a brief introduction, information on the immediate effect of nerve injuries is presented. Most of the wounded felt immediate weakness or loss of use over the area of an injured nerve's distribution, but did not initially lose consciousness unless hit in the head or neck. This was important because the patients could describe exactly how they felt from the moment of injury to arrival at a medical facility. Upon comparing the case histories of their patients, the doctors found motor function more often was impaired than was sensory function. They also found that pain most commonly occurred around the wound area but could be referred.[6]

When a patient arrived at Turner's Lane, the doctors took his history and gave a thorough physical examination. Then the case was recorded in vivid detail. The case descriptions are especially remarkable in their precision as the Army Medical Department's recordkeeping system at that time was chaotic and unreliable.[7]

After the first few chapters, Mitchell devoted the rest of his work exclusively to peripheral nerves. The neurological team believed that injuries to peripheral nerves arose from a variety of mechanisms. Among these mechanisms were direct injury, contusions, injury resulting from dislocation, pressure from cicatrical tissue, "commotion" from near passage of a missile, and extension of disease processes from wounded to healthy nerves. Detailed examples are given in all of these categories. The last two categories were controversial. The authors thought near passage of a missile caused nerve "commotion" resulting in paralysis without grossly visible nerve damage. They were unsure how the injury of one peripheral nerve eventually could cause malfunction of an area controlled by another nerve in that extremity. They felt that it was either a reflex effect or inflammation at the wound that spread backwards along the nerve to one or more stems of the main trunk.[6]

Mitchell and his colleagues used the data provided by their many patients to record in great detail the effects of peripheral nerve injury on the muscles and skin of the injured extremity. These effects were found to follow a distinct time sequence. For example, if a patient with a nerve injury was sent to Turner's Lane a while after the injury occurred, the doctors could deduce what stage of degeneration the nerve was in by past experience.

The most visible effect observed in an injured extremity after a nerve injury was atrophy of the muscles innervated by the damaged nerve. If the nerve was completely sectioned, atrophy resulted and continued "until nothing is left but bone and degenerated areolar structures cov-

ered with skin. . . ."[6] Partial or complete regeneration of peripheral nerves supplying the atrophied muscles was possible. However, Mitchell believed that without electrodiagnostics, it was difficult to detect this due to the atrophied state of the muscle.[6] The authors attempted to explain the cause of atrophy. They were in agreement with Duchenne that atrophy is not due to central influence. Since paralysis and atrophy were not necessarily observed to be linked, Mitchell postulated that there are motor, sensory, and nutrient nerve fibers in nerves that could be separately injured. Furthermore, he believed the nutrient fibers to be of sympathetic origin.[6]

Sensory loss was found to be common in nerve injury, although less common than motor loss. Mitchell felt this was true because "slight defects of sensibility over large surfaces are not so easy of appreciation as losses of motility."[6] Sensory fibers also seemed to regenerate more quickly. Intense pain was documented frequently with nerve injuries. A neuralgia caused by partial damage to peripheral nerves, termed causalgia, first was described in detail by the Turner's Lane doctors.[2] Mitchell's description of causalgia still is believed to be the best available.[10] Mitchell writes that patients described causalgia as "burning, mustard hot, and a red hot file rasping the skin. . . ."[6] In many cases, the pain lingered for months. Mitchell described the typical behavior of a patient suffering from causalgia: "As the pain increases the general sympathy becomes more marked. The temper changes and grows irritable, the face becomes anxious, and has a look of weariness and suffering. The sleep is restless and the constitutional condition, reacting on the wounded limb, exasperates the hyperaesthetic state, so that the rattling of a newspaper, a breath of air, another's step across the ward, the vibrations caused by a military band, or the shock of the feet in walking gives rise to increase of pain. At last the patient grows hysterical. . . . He walks carefully, carries the limb tenderly with the sound hand, is tremulous, nervous and has all kinds of expedients for lessing his pain."[6]

The description of damage caused by nerve lesions concludes with a chapter on the effects of nerve damage on muscle movement. The most obvious effect on muscle movement was paralysis. This could be temporary or permanent depending on the extent of nerve damage. Another effect observed in many cases was muscle spasms and tremors. The authors felt that this could be due to an alteration in the way muscle is excited by nerve. Finally, changes in the "nutrition of joints" was thought to limit movement due to painful inflammation.[6]

The last section of the book is the most important. In this section, the authors describe their techniques of diagnosis and treatment. Through a thorough history and physical examination, the neurologists first tried to reconstruct the mechanism and location of the supposed nerve injury. If it appeared that there was nerve damage to an extremity manifested by paralysis, paresthesia, or skin alteration, electrodiagnosis was used for confirmation. A faradic current was introduced on the skin of the injured extremity and the muscle believed to be denervated was stimulated. If the muscle did not contract, the neurologists felt denervation occurred.[6] Mitchell was enthusiastic about electrodiagnosis stating, "The certainty with which each muscle may be excited is so wonderful that by this . . . it is possible to reach accurate conclusions as to the function of the various muscles."[6]

Mitchell also thought the use of faradic currents was a major mode of therapy writing. "The one great means in the treatment of paralysis from deficit of innervation is electricity."[6] He felt that regeneration and recovery were enhanced by repeated faradic stimulation, although he admitted "sensibility is such (in wounded muscles) to make the use of the battery exquisitely painful."[6] Other progressive forms of therapy included massages, douches, and calisthenics aimed at strengthening and restoring function of physical extremities.[6]

After Mitchell's era, studies in peripheral nerve damage continued, especially during World Wars I and II. Many of the clinical findings Mitchell observed were repeated in these wars. His book was used widely by doctors who had to cope with traumatic nerve injuries.[6] Some of the findings Mitchell documented were observed again such as "nerve commotion" by near passage of bullets.[10] Other ideas such as the benefits of electrotherapy in speeding recovery of peripheral nerve injuries have proved wrong.

There still is much to be learned about peripheral nerve injuries. Although advanced diagnostic techniques and new treatments such as microsurgical repair exist, many aspects still elude neurologists. Advances will be made in understanding these problems and others by the next generation of neurologists who will follow the example of the Turner's Lane doctors' selfless dedication to the advancement of their profession for the benefit of their patients. ■

Mr. Salerno was awarded the Stephen Wickes's Prize in the History of Medicine for the complete version of this paper with references. Mr. Salerno is a third-year medical student at the University of Rochester, School of Medicine, New York. Requests for reprints may be addressed to Mr. Salerno, 73 Marshall St., Apt. 9, Rochester, NY 14607.



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Mediastinal Mass Following Esophageal Surgery

Alan M. Saunders, MD
Lawrence C. Swayne, MD
Jeanne R. Schwartz, MD
Mark W. Moritz, MD

In this Radiology Rounds, *the authors report the computed tomographic findings of a patient with an infected esophageal mucocele that formed within one month after repair of a perforated paraesophageal hiatus hernia. The patient was a 78-year old male.*

Our patient, a 78-year-old male, had undergone emergency esophagogastrectomy for acute volvulus of the stomach through a paraesophageal hernia with necrosis and perforation. The operative procedure consisted of a proximal gastrectomy with feeding gastrostomy, removal of several centimeters of the esophagus with closure of the proximal and distal ends, and the formation of a proximal cervical esophagostomy. He subsequently was transferred to our hospital for dialysis with respiratory failure, sepsis, and renal failure. Exploration later was required to repair a gastrostomy leak and to drain a right subphrenic abscess.

The patient's sepsis gradually responded to appropriate antibiotic therapy but later recurred with fever (38°C), leukocytosis (WBC = 18,500 cells/μl), and positive blood cultures for *Staphylococcus aureus.* Chest x-rays showed surgical clips, bilateral infiltrates, and pleural effusions. One month after the initial surgery, a computed tomography (CT) scan (Figures 1 and 2) showed a large 14 x 8 x 10 cm fluid collection behind the heart with a barium-fluid level.

DISCUSSION

The retroesophageal mass initially was thought to be that of a pouch from a gastric pull-through operation; however, no oral contrast had been administered to the patient. Review of the original surgical report revealed extensive necrosis had precluded a primary reanastomosis procedure. This raised the possibility of a mediastinal abscess or an esophageal mucocele secondary to partial esophagectomy and creation of a blind esophageal loop. The patient was re-explored through the original left cervical incision, and a large infected esophageal mucocele was encountered. An esophageal drainage tube was placed and one liter of purulent material was drained yielding positive cultures for *Staphylococcus aureus.* A follow-up CT scan (Figure 3), performed four days later, showed complete collapse of the distal esophageal remnant around the indwelling sump catheter.

Surgical bypass of the esophagus has been employed for the treatment of caustic or non-dilatable benign strictures, esophageal perforation, and palliation of advanced cancer.[1] The native esophagus may be left

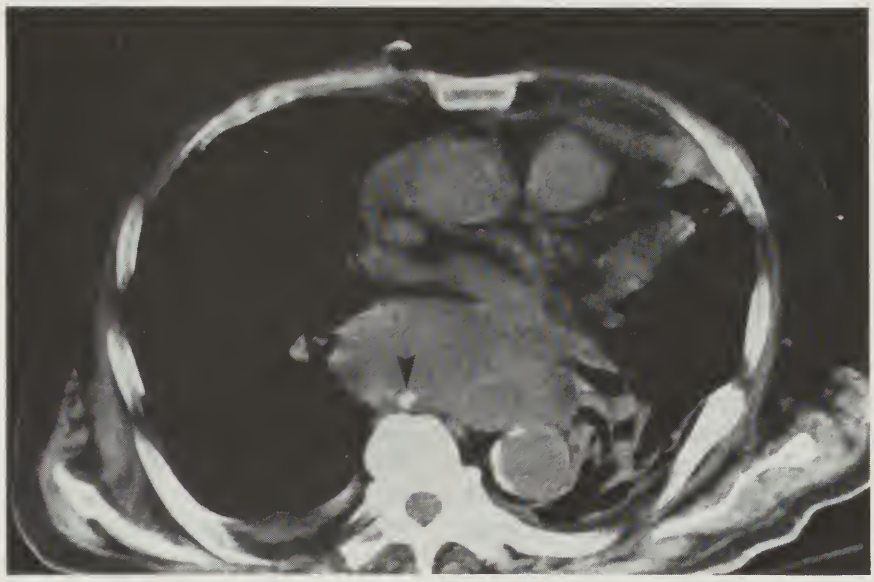


Figure 1. CT scan at a level 3 cm below carina shows a large retrocardiac fluid collection with residual barium (arrowhead) and an extensive inflammatory reaction adjacent to the aorta.



Figure 2. CT scan at the level of the esophagogastric junction again shows the mucocele with residual barium (arrowheads). Fluid and barium (small arrow) adjacent to the aorta indicates the presence of a perforation. Notice the similar appearance to a gastric interposition.



Figure 3. CT scan following external drainage shows complete collapse of the mucocele around the indwelling sump catheter. Extensive periaortic inflammatory reaction persists.

in situ following closure of both upper and lower ends. Symptomatic mucocele formation in the excluded segment is considered to be a rare clinical event.[2]

Experimental evidence in dogs, however, has shown that small cysts commonly appear within weeks following surgery. These cysts usually are self-limited and remain asymptomatic, due to pressure-induced atrophy of the secreting glands.[4] Symptomatic mucoceles may develop in the presence of chronic irritation of the mucosa that may be comprised of either squamous or columnar epithelium.[2] In cases with initial ischemia, contamination of the esophagus, or possible hematogenous seeding from another septic focus, one should consider the potential abscess formation within an esophageal mucocele.

Awareness of the possible existence of an esophageal mucocele is essential in the evaluation of these patients. The clinical signs and symptoms are pain, effusions, and an elevated white blood cell count; chest radiographs are nonspecific.[2] A CT scan is diagnostic and will show a fluid-filled retrocardiac mass;[1,2] however, without a proper history, the mass could be mistaken for an interposed stomach. Treatment options include: CT-guided percutaneous drainage, external tube or internal drainage, and complete esophagectomy. In the absence of extensive inflammation or scarring, complete excision of the esophagus is preferred.[1,2]

DIAGNOSIS

Infected esophageal mucocele secondary to partial esophagectomy and creation of a blind esophageal loop was our diagnosis. ■

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Drs. Saunders, Swayne, and Schwartz are affiliated with the Department of Radiology, and Dr. Moritz is affiliated with the Department of Surgery, Morristown Memorial Hospital. Dr. Swayne and Schwartz are affiliated with the Department of Diagnostic Radiology, College of Physicians and Surgeons, Columbia University, New York.

The paper was submitted in January 1991 and accepted in April 1991.

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1991 Policy Research Perspectives

American Medical Association

Three new policy perspectives—the Medicare physician payment schedule; economic status of the elderly; and new technology and Medicare expenditures—are discussed, according to current directives of the American Medical Association.

NEW MEDICARE PHYSICIAN PAYMENT SCHEDULE

In 1992, the transition will begin to a new Medicare payment schedule for physician services. Under the schedule, payments for each service will equal a relative value times a monetary conversion factor. Legislation requires that the initial conversion factor for the new payment schedule be budget neutral, i.e. total payments under the new schedule be identical to what they would have been if the current payment method remained in effect. The main issue in applying this criterion is what allowance, if any, should be made for "volume offsets," or behavioral responses to changes in payments for physician services. Since one intention of the new schedule is to deliberately raise many payment rates while lowering others, it is expected that both the supplies and demands for many services will be affected, resulting in increased utilization of some services and declining utilization of others. The behavioral responses of physicians and patients must be anticipated in the calculation of the initial conversion factor if it is to be budget neutral.

Budget forecasters at both the Health Care Financing Administration and the Congressional Budget Office have employed volume offset assumptions in their projection methodology for many years. For instance, the assumption has been made that for each 10 percent reduction in payment rates, volume increases by up to 5 percent. However, the historical assumptions may not be entirely suitable for the new problem of calculating the budget-neutral conversion factor.

On November 15, 1990, the AMA Center for Health Policy Research and the Project HOPE Center for Health Affairs convened a workshop of 30 health economists and policy analysts to discuss research evidence regarding physician responses to changes in Medicare payment rates. Of particular interest were the implications of recent investigations for appropriate volume offset assumptions used in calculating the conversion factor.

Four research papers on the issue were reviewed and discussed by government, academic, private and trade association researchers, and policy analysts. While some of the research efforts were not directly motivated by the particular problem of the volume offset, they all employed models, data, and econometric techniques necessary to develop quantitative estimates of the behavioral responses at issue:

- Results of analyses and authors' interpretations varied widely. No simple, consistent interpretation can be given to the results reported in the papers.
- Many of the results were imprecise so that no judgment could be made about the extent or even the direction of volume change in response to changes in payments for services.
- In some cases, results were conflicting. Based on these findings, a wide range of values for a volume offset could be considered consistent with the state of knowledge.

Workshop participants informally discussed each research effort in terms of generally accepted criteria for evaluating econometric modeling research. For many reasons, it was agreed that arriving at conclusions on the volume offset for the initial conversion factor from currently available research results may be problematic. A number of suggestions for further research were discussed, many directed at improving the research database.

A significant outcome of the workshop was to place in question the arbitrary assumptions employed by federal agencies regarding volume offsets to Medicare physician payment rate changes.

Despite the need for further research, determining the budget neutral conversion factor to implement the new Medicare payment schedule is an immediate problem. Since the available research provides, at best, very limited guidance for quantifying the behavioral response to the new payment schedule, it remains to be seen how the behavioral offset might be determined.

ECONOMIC STATUS OF THE ELDERLY

Recent cuts in the growth of federal funding for Medicare have directly affected physicians, hospitals, and beneficiaries. The equity of overall cuts in Medicare spending and of the distribution of those cuts among physicians, hospitals, and beneficiaries is sure to be a matter of continued debate. One issue important to this debate is the relative economic standing, or ability to pay, of the Medicare population and of the elderly in particular.

The economic well being of the elderly relative to the nonelderly is difficult to assess, partly due to differences in household size and the composition of income between these two groups. A report prepared by Richard J. Wilke, PhD, and Kurt D. Gillis, PhD, of the AMA Center for Health Policy Research summarized the economic standing of the elderly relative to the nonelderly.

The report found that a range of conclusions regarding the financial status of elderly Americans can be drawn depending on the choice of the measure of economic status and adjustments for household size. Households headed by the elderly tend to have lower incomes, but also are smaller in size and have a greater concentration of wealth in the form of financial assets and home equity. As a result, the elderly tend to look poorest compared to the nonelderly in terms of household income. To illustrate:

- Census Bureau data indicate that median elderly household income was $14,923 in 1988, compared to $27,225 for all households.
- In contrast, net worth of the average elderly household was $59,680 in 1984, compared to $32,600 for all households.

Because elderly households are smaller, the income and net worth comparisons are more favorable to the elderly when expressed on a per capita basis. Per capita comparisons, however, may overstate the relative financial status of the elderly because some expenses, such as housing costs, are more economical when spread over bigger households. On the other hand, income statistics often include only money income. The elderly may benefit more from some forms of nonmoney income (such as implicit rent from owner-occupied housing) and employer or government provided health care benefits (due to subsidies provided through the Medicare and Medicaid programs).

Recent research aimed at providing a more accurate picture of the economic status of the elderly is summarized in the Center report. In this research, adjustments were made to account for differences in income requirements by household size and the receipt of nonmoney income. With these adjustments, average income of the elderly in 1986 was estimated to be 17 percent higher than the average nonelderly income, providing a different picture of the economic status of the elderly than the household money-income figures reported.

A better indicator of the economic impact of changes in federal funding for Medicare and Medicaid for those most in need may be the poverty rate (proportion of the population falling below the poverty line). In 1986, household money income fell below the poverty line for: 12.4 percent of the elderly; versus 13.8 percent of the nonelderly.

Including nonmoney income reduces the 1986 poverty rate for the nonelderly to 10.9 percent, but reduces the elderly poverty rate even more, to 5.7 percent. The poverty figures for the elderly show marked improvement since the late 1960s when, for example, over one-fourth of elderly families lived below the poverty line—an improvement largely due to the increasing generosity of Social Security benefits. However, some segments of the elderly population, particularly widows and the very old, continue to experience significantly higher rates of poverty than the remainder of the population.

Simple financial statistics provide evidence for both sides of any debate over the ability to pay of elderly Americans. However, the general notion of the existence of a large elderly underclass may be somewhat outdated. Poverty rates of those over 65 now are comparable to those of the remainder of the population. Income adjusted for household size and nonmonetary sources also is comparable between the elderly and nonelderly. Greater attention may need to be focused on how the burden of funding cuts is distributed within the Medicare population.

NEW MEDICAL TECHNOLOGY AND MEDICARE EXPENDITURES

Recent Medicare reforms link physician payment levels to growth in outlays for physician services. Although the linkage is weak, the thrust of these reforms is to decrease (increase) payment levels when actual expenditures exceed (are below) a predetermined annual target level of growth known as the Medicare Volume Performance Standard (MVPS). It is important that the MVPS be set accurately and fairly so that future payment levels are reasonable.

Because the MVPS is supposed to reflect an "appropriate" rate of growth in expenditures, changes in the beneficiary population, inflation, access to care, the degree of inappropriate care, and the impact of technology are important issues in establishing annual volume growth targets. Of particular

interest has been the impact of technology, since anecdotal evidence suggests that it has been an important cause of increasing health care costs. However, the MVPS for 1991 omitted this factor because knowledge of the impact of new technology on Medicare program costs is virtually nonexistent. This omission particularly is disquieting because it encourages lower MVPS targets that, in turn, may result in lower payments to physicians.

The only existing estimate of the impact of new technology on Medicare program costs was made by the Physician Payment Review Commission. By examining the costs of individual new technologies, such as MRIs or CAT scans, the Commission found that new technology had a surprisingly small impact on the volume of Medicare services.

In a recent study, AMA Center for Health Policy Research economist David W. Lee, PhD, challenged this finding by exploring how services that are complementary, or related, to the new technology service may influence the cost estimate. These related procedures include office visits or other services that are provided in conjunction with the new technology service. In addition to analyzing the conceptual problems in estimating the cost impact of new technology and reviewing previous research on this topic, the principal findings of Dr. Lee's analysis are: Although the estimated cost of new technologies is relatively small, including the effect of related procedures increases the estimated cost by as much as 50 percent. The estimated growth in the volume of services resulting from new technology may rise by as much as 42 percent when related procedures are taken into account.

Dr. Lee's research illustrates the importance of including related procedures when estimating the share of growth in Medicare physician services expenditures that can be attributed to new medical technology. For policymakers who must determine MVPS targets in the future, Lee's research has two important implications: Rough estimates of the impact of technology on Medicare program costs are feasible and should be considered when the MVPS is determined. Both new technologies and related procedures should be examined when targeted rates of growth in Medicare spending are determined.

For more information on policy research perspectives, contact the AMA Center for Health Policy Research, Chicago, Illinois. ■

MSNJ Annual Meeting



Joseph A. Riggs, MD, and Governor Jim Florio discuss the state of New Jersey's health at a private conference at MSNJ's Annual Meeting.



Douglas M. Costabile, MD, awards Dr. Riggs, the presidential plaque upon his inauguration at the Annual Meeting.



William Ryan, MD, and John Franzoni, MD, debate JEMPAC concerns for the 1991-1992 legislative session.



The MSNJ House of Delegates convenes at the Taj Mahal Casino/ Resort in Atlantic City.



Angelo Agro, MD, John Capelli, MD, Dr. Riggs, and Palma Formica, MD, review agenda items for the House of Delegates session.



For their 50 years of service, New Jersey physicians were awarded the Golden Merit Award and honored at a luncheon at the MSNJ Annual Meeting.



George T. Hare, MD, Dr. Riggs, and Harry M. Carnes, MD, celebrate at the inaugural dinner-dance.



Dr. and Mrs. Riggs and Dr. and Mrs. Costabile attend the inaugural dinner-dance at the Annual Meeting.



The Medical Society of New Jersey Auxiliary inaugurates its 1991-1992 leadership.



The 1991-1992 Medical Society of New Jersey Board of Trustees: (front, left to right): William E. Ryan, MD; Joseph A. Riggs, MD, president; Joseph N. Micale, MD; Fred M. Palace, MD; (second row, left to right): Gerald H. Rozan, MD; Anthony P. Caggiano, Jr, MD; Irving P. Ratner, MD; Leticia V. DeCastro, MD; Devang Shah; Philip J. Jasper, MD; Angelo S. Agro, MD; George T. Hare, MD; (last row, left to right): Joel S. Cherashore, MD; John J. Pastore, MD; R. Gregory Sachs, MD; Michael M. Heeg, MD; and Shah M. Chaudhry, MD. Absent from the picture: Stevan Adler, MD; Douglas M. Costabile, MD; G. Gerson Grodberg, MD; Louis L. Keeler, MD; and A. Ralph Kristeller, MD; Carl Restivo, Jr, MD; and Bernard Robins, MD.

DOCTORS' NOTEBOOK

TRUSTEES' MINUTES

A regular meeting of the Board of Trustees of the Medical Society of New Jersey was held on June 9, 1991, at the executive offices in Lawrenceville. Detailed minutes are on file with the secretary of your county society. A summary of significant actions follows:

President's Report.

1. Membership Recognition. Suggested a recognition program be considered for physicians who attain 30 years of uninterrupted membership in MSNJ.

2. Communication Workshop. Noted that a workshop is being organized to promote effective communication by those in leadership positions when dealing with the media and making publication presentations.

3. International Medical School Graduates. Encouraging international medical graduates to become involved in MSNJ activities.

4. NJ Obstetrical and Gynecological Society. Will submit to the MSNJ Committee on Maternal and Child Care, a copy of an obstetrical review plan to ensure optimum quality of perinatal care and to document the quality of care.

5. AMA Dues Billing Plan. Noted that the AMA has heard objections from New Jersey and other states concerning its dues billing format for membership development; implementation of the plan is waived at the present time for those states experiencing difficulty with it.

6. SBME License Renewal Application. Authorized Mr. Maressa to file for an injunction against the State Board of Medical Examiners (SBME) license renewal application forms.

7. Meeting Schedule. Noted the following meeting dates for the Board of Trustees of the Medical Society of New Jersey, for the upcoming administration year: September 15; October 20; November 17; December 15; January 19, 1992; February 9, 1992; March 15, 1992; and April 15, 1992.

Executive Director's Report.

1. Membership and Financial Statements. Noted that the membership report was supplied and that the financial statements for the period ending April 30, 1991, were reviewed and approved.

2. Litigation. Noted the following items: no further appeal action will be taken on the medical malpractice surcharge; MSNJ's litigation on the no-fault act has moved to the Appellate Division; legal briefs opposing the rule to authorize physician assistants have been filed; Dr. Riggs gave testimony on SBME business practice rule; a response from HCFA concerning the implementation of the law (entitlement of quarterly incentives to physicians who rendered services in health manpower shortage areas) and when retroactive payments to eligible physicians will be available; the case of SBME versus Sinha (disciplinary action taken by SBME against Dr. Sinha for failure to provide supervision in a situation where he had no obligation to be personally present) was remanded for clarification within a specific time period; and announcement of the Board of Directors of the New Jersey State Medical Underwriters: Vincent Maressa, chairman, Dr. Paul J. Hirsch, vice-chairman, Dr. Palma E. Formica, secretary/treasurer.

3. NJ State Department of Health Anesthesia Regulations. Noted that MSNJ sent a communication to the commissioner of health stating that the proposed regulations were consistent with New Jersey law and sound medical practice.

4. Current Legislation. Noted the following items: S-3251 (Health Care Reforms) is pending in the Assembly; S-3510 and A-4347 (Physician Assistants) are scheduled to be heard before the Senate Committee on Labor, Industry, and Professions; S-3491 and A-4585 (Nurse Practitioners) are scheduled for a hearing in the Senate and Dr. Riggs will testify in opposition; and A-4090 (Physical Therapists) is posted for an Assembly vote.

5. MedAC/JEMPAC Contributions. Noted that a report on this political action effort will be presented at a future meeting.

UMDNJ and NJ Hospital Associations. Received monthly reports for information.

Council on Medical Services. Agreed that the AMA-New Jersey Delegation would review Missouri's resolution (allowing patient and physician freedom of choice to construct an economic service delivery system outside of Medicare Part B without penalty), if in concurrence with the position recommended by the Council on Medical Services, and would support it. Also, approved the following recommendation:

That the Board of Trustees of the Medical Society of New Jersey notify the Prudential Insurance Company that review of a physician's care or his fee should be conducted by a physician of the same specialty.

Committee on Medical Education. Approved the following:

Resolved, that the following measures be taken to sustain a cooperative working relationship between UMDNJ and MSNJ;

That MSNJ designate a position on its Committee on Medical Education

for a representative of UMDNJ;

That MSNJ consider cosponsorship of programs with UMDNJ when appropriate;

That MSNJ include UMDNJ for alternative CME opportunities for hospitals and other organizations that do not have the resources to be independently accredited for designating category I AMA credit;

That MSNJ serving as a facilitator for focused/individualized continuing medical education include UMDNJ as a resource in the planning, implementation, and evaluation of such programs.

And, thanked Drs. Bernardo Toro-Echague, David Swee, and William Vaun for their outstanding work on the MSNJ *CME Procedure and Instruction Manual* and *CRR Application.*

Committee on Conservation of Vision. Approved the following:

That the 1991 Eye Health Screening Program be held the week of September 23, 1991.

Task Force on AIDS. Voted to file the report of the Task Force on AIDS. Also, the text of Resolution #4, the report of the Task Force on AIDS, and a staff analysis will be distributed to the Board of Trustees, the AMA Delegation, county medical societies, presidents of hospital medical staffs, and vice-presidents of medical affairs of all New Jersey hospitals, to assist them in developing policies on AIDS testing.

Hospital Medical Staff Section. Adopted the following resolutions:

Resolved, that MSNJ recommend to the New Jersey State Department of Health, Division of Health Facilities Evaluation and Licensing, that the mandated age of ICU patients requiring pediatric consultation be changed from 18 to 24 years of age.

Resolved, that MSNJ vigorously petition the New Jersey State Department of Health to conduct its inspection of hospitals in conjunction with the Joint Commission on Accreditation of Health Care Organizations inspections.

New Business. Was not in favor of lowering the percentage requirement for specialty society representation in the MSNJ House of Delegates and rejected the request made by the New Jersey Chapter of the American College of Cardiology for representation.

Correspondence. Noted that Mr. Everett Bryant, Pennsylvania Blue Shield, will provide information to the provider community noting that Part B carriers be required to provide physicians with an explanation of Medicare benefits on all nonassigned claims; he outlined the ways for physicians to obtain this information: a written request by the patient or an oral request from the patient. □

UMDNJ NOTES

Stephen Weinstein returns to UMDNJ Board of Trustees. Stephen S. Weinstein, who served on the Board of Trustees of the University of Medicine and Dentistry of New Jersey (UMDNJ) from 1976 to 1984, has rejoined the Board. One of the state's most respected attorneys, Mr. Weinstein's expertise will allow him to contribute significantly to the Board and to UMDNJ. Mr. Weinstein is a certified civil and criminal trial attorney. Since 1985, he has served as a trustee of the Sammy Davis, Jr National Liver Institute.

Preventive TB treatment advised for HIV-infected patients. To extend lives and curb the AIDS-linked climb in tuberculosis (TB) rates, most HIV-infected patients should receive preventive tuberculosis drug therapy even without a tuberculin test, investigators at UMDNJ-New Jersey Medical School have shown. Based on a computer analysis of a hypothetical AIDS case, the researchers reported that isoniazid (INH) would add almost a year to the lives of individuals infected with both HIV and TB. They recommend that the drug be given to HIV-positive black males, white males, and white females without tuberculin testing even when their suspected potential of TB infection falls as low as 3 to 8 percent. The study was led by Dr. Lee Reichman, professor of medicine, and Dr. Theresa Jordan, assistant professor of medicine, UMDNJ-New Jersey Medical School, Newark.

Drugs effective against age-related hypertension. Drug treatment can reduce significantly the number of strokes and heart attacks for men and women over 60 who have age-related hypertension. Investigators at UMDNJ-Robert Wood Johnson Medical School, New Brunswick, reported this finding as 1 of 16 research centers to participate in a major national clinical trial. The study of age-related hypertension was directed by Dr. John Kostis, chairman of the Department of Medicine. The results of the five-year research project potentially can improve the outlook for some three million older people with isolated systolic hypertension (ISH). The condition affects the elderly, causing only the systolic pressure to increase.

Graduate becomes first to gain dual degrees. UMDNJ graduate Maryellen Leddy Hanley has become the first person to earn simultaneously a medical degree from UMDNJ-Robert Wood Johnson Medical School and a master's degree in public health awarded jointly by UMDNJ and Rutgers University. Dr. Hanley plans to do research in maternal/fetal medicine after a residency in obstetrics/gynecology at Robert Wood Johnson University Hospital, New Brunswick, the core teaching hospital of UMDNJ-Robert Wood Johnson Medical School.

UMDNJ welcomes 18 into Scholars Program. UMDNJ inducted 18 high school seniors into an honors program designed to prepare them for medical school. The Scholars Program is tuition free and offered annually by

UMDNJ-School of Osteopathic Medicine, Stratford, to gifted high school seniors considering careers in medicine. This year the program graduated 22 scholars. The new group will begin the intense 28-week course of study when they enter their senior year at 13 high schools in Camden and Gloucester counties. They are excused from school twice weekly to take advanced studies with faculty of the medical school. They observe diagnostic, laboratory, and clinical procedures, keep a journal, and write papers on what they learn.

Textbook is 'first' for headache treatment. Dr. R. Michael Gallagher, acting dean at UMDNJ-School of Osteopathic Medicine, has written the first textbook devoted solely to the pharmacological treatment of headaches. The comprehensive textbook includes contributions from internationally renowned headache researchers and experts. Dr. Gallagher, professor of clinical family medicine, specializes in headaches and has written several books and chapters on the subject. ☐ Stalney S. Bergen, Jr, MD

MSNJ AUXILIARY

Making a speech? Handling a newspaper interview? Doing a television appearance? Your experience can be a public relations nightmare or a golden opportunity to promote the goals and interests of the medical profession. To make your words work, and to make you a confident, persuasive spokesperson for medicine, preparation for press time is necessary. Recognizing the importance of training our leaders, MSNJ and the Auxiliary are cosponsoring a media training session, entitled, "Medicine and the Media," on Wednesday, September 25, 1991, from 9:00 A.M. to 12 NOON at MSNJ headquarters.

The workshop will focus on various practical techniques used to develop the art of communication. Jane Coughlin, AMA director of Internal Communications (photo, page 522), will teach a seminar, "How To Present Yourself in Public." The session will offer information on how to make a good presentation, good speechwriting, podium presentation tips, and handling media interviews.

Ms. Coughlin has worked for the AMA since 1979. She serves as principal communications consultant to 600 featured medical societies, on behalf of AMA, and produces a variety of communications plans for in-house activities and product promotions. Ms. Coughlin teaches training seminars to physicians throughout the country, aimed at enhancing podium speaking skills and media interview techniques. In addition, she has special expertise in AIDS public education and has published articles in peer-reviewed medical journals on how to communicate information effectively.

Vani Rangachar, health editor for the *Asbury Park Press*, will give the second presentation, "Newspaper Coverage of Medical Topics: Ways to Get Medical Services Recognized in the Community." Ms. Rangachar will discuss newspaper coverage of medical topics, recognizing news potential, pitching stories, and recognition of medical services.

MSNJ and Auxiliary leaders, and other interested physicians, are urged to attend "Medicine and the Media." There is no charge for the workshop. Reservations can be made by calling the Auxiliary office, 609/896-1766. ☐ Marion Geib

MEETINGS OF THE BOARD OF TRUSTEES of the Medical Society of New Jersey

September 15, 1991
October 20, 1991
November 17, 1991
December 15, 1991
January 19, 1992
February 9, 1992
March 15, 1992
April 15, 1992

Meetings of the Board of Trustees are open to all physicians. The meetings on September 15, 1991, and March 15, 1992, are OPEN FORUMS, to allow physicians the opportunity to stand up and be heard. If you would like to attend the OPEN FORUMS, please contact Diana Gore, MSNJ headquarters, 609/896-1766.

AMNJ NEWS

The Academy of Medicine's Annual Awards Dinner held on May 29, 1991, at the Chanticler in Short Hills, was a major success. A capacity gathering of 420 guests attended to honor our award recipients and help install our officers for the 1991-1992 year. Our Edward J. Ill Award recipient, Dr. Robert V.P. Hutter of Livingston and our Citizen's Award designee, Vincent A. Maressa of Titusville, were eloquent in their response. A special touch to the evening was the presentation by Dr. Gerald Shapiro of lapel pins to our past-presidents in attendance.

The location for our 1992 event will be the Chanticler and the date will be Wednesday, May 27, 1992. The Awards Committee, under the chairmanship of immediate past-president, Dr. Stanley Bresticker, is soliciting nominations for 1992. The deadline for receiving nominations is September 13, 1991.

New AMNJ officers for 1991-1992 are: President, Dr. Gerald Shapiro; President-Elect, Dr. George J. Hill; 1st Vice-President, Dr. John L. Krause; 2nd Vice-President, Dr. Palma Formica; Secretary, Dr. Richard Dixon; and Treasurer, Dr. Alan Hershman.

The Academy's staff is preparing the *Annual Calendar for 1991-1992*. The *Calendar* will include many items of interest including CME activities for the upcoming academic year, a list of available roving symposia topics, an application to participate in our Speaker's Bureau, and a list of affiliated specialty societies and their presidents.

The 16th Annual New Jersey Orthopaedic Symposium cosponsored by the Academy of Medicine of New Jersey and the New Jersey Orthopaedic Society will be held on Friday and Saturday, October 11 and 12, 1991, at the Somerset Marriott. Dr. Joseph Billotti, program chairman and Dr. Alfred Tria, program secretary, have arranged for an outstanding program on trauma.

The Complications/Resident's Thesis Conference will be held on Friday from 2:00 to 5:45 P.M. Members are encouraged to bring cases and complications for presentation. A cocktail party and dinner will follow at 6:00 P.M., including a special after-dinner speaker.

The all-day program on Saturday will feature the following guest speakers: Dr. Jesse Jupiter of Harvard Medical School; Dr. Casey Lee of UMDNJ; Dr. Dana Mears of the Institute of Orthopaedic Specialists in Pittsburgh; Dr. Howard Rosen of the Hospital for Joint Diseases; Dr. Roy Sanders of the Florida Orthopaedic Institute; and Dr. Donald Wiss of the University of Southern California. The symposium is designed to provide an opportunity for orthopaedists in the tri-state area to hear timely topics of current interest presented by national leaders in various fields.

The education program coordinator at the Academy, under the direction of the Education Committee, presently is updating the computerized Speaker's Bureau. A significant number of new topics have been added at this time and many have been deleted. It is important that we maintain a current listing of fellows who wish to participate in the roving symposia series. If you have new topics that you would like to address, please contact Ms. Mae Slabicki. It would be helpful if you would send an updated CV for our files. The Academy is in the process of preparing a survey to assess the relationship between lecturing for the roving symposia series and patient referrals to the physician lecturers. ☐ Gerald Shapiro, MD

LEGISLATIVE BULLETIN

The accompanying list presents the official position of the Medical Society of New Jersey regarding bills currently in the Legislature. The Society has adopted the following regular range of official positions concerning proposed legislation:

Active Support: All-out support for the measure.

Active Opposition: All-out opposition for the measure.

Conditional Approval: To indicate that the approval of the Society is conditional, subject to elimination of the unsatisfactory elements of the bill that are pointed out.

Approval: Commended as satisfactory, but not actively supported.

Disapproval: Rejected as unsatisfactory, but not actively opposed.

No Action: Considered, but not regarded as significant or relevant to the proper interest of the Society.

Senate/Assembly (Active)

S-3033-Orechio—Worker's Compensation (same as A-4057). Requires that when an employer provides a list of designated physicians, at least one chiropractor must be included. **Active Opposition.** Today there are various health care delivery systems, HMOs and PPOs, that employers purchase and these systems define providers by policy. This legislation would prevent employers from selecting the health practitioners that they wish. (It was recommended that MSNJ meet with the New Jersey Chamber of Commerce in an effort to create legislation that might lead to a more prudent and financially responsible program of worker's compensation in the state of New Jersey.)

S-3218-Rice—HIV Testing. Any person convicted of sexual assaults must be tested for HIV sensitivity, and the results of the test are to be disclosed to the victim. **Active Support.**

S-3251-Codey—Health Care Reform. A sweeping omnibus bill that, among other things, applies certificate of need to doctors, prohibits doctors from referring patients to a service in which they own an interest, prohibits dispensing beyond a four-day supply, and provides for a holographic override on generic prescriptions. **Active Opposition.** Physicians should not be prohibited from referring patients to a service in which they own an interest since they already are required to disclose their financial interest, and certificates of need should not be required for doctors in private practice.

A-2212-Spadoro—Medical Waste. Imposes criminal penalties for illegal disposal of medical waste; increases criminal penalty for illegal disposal of hazardous waste. **Active Opposition.** Physicians have not been adequately educated by the New Jersey State Department of Environmental Protection regarding the generation, transport, storage, or disposal of special medical waste to comply with the registration act. Current law adequately addresses the issue but a greater effort at meaningful implementation is necessary.

A-3289-Patero—Health Insurance for the Unemployed. Establishes two state-operated plans for the unemployed. Appropriates $50 million from the state disability fund as a start-up loan. Continued funding is provided by diversion from the unemployment compensation fund. Anyone collecting unemployment would be eligible for state-sponsored health and life coverage. **Active Opposition.** This is unnecessary legislation and it would create a disability and worker's compensation insurance crisis.

A-4145-Ford—Commissioner of Health. Amends current law to provide the commissioner of health may be a physician or a nurse. **Active Opposition.** The health care needs of our population require that a licensed physician serve in the position of commissioner of health.

A-4268-Mullen—Physician Dispensing. Prohibits physicians from dispensing more than a four-day emergency supply of drugs except in certain instances. **Active Opposition.** Compromises the physician's ability to treat patients properly.

A-4282-(AIC Substitute)—Health Care Reform. Omnibus reform bill that would adversely affect physicians by requiring the prescription of generics except when holographically written and also would apply certificate of need to physicians at the $1 million threshold. **Active Opposition.** Certificates of need should not be required for doctors in private practice and the liberalization of the generic law is not indicated at this time.

A-4284-Mullen—Generic Prescriptions. Mandates the use of generics unless the prescriber holographically overrides. **Active Opposition.** Liberalization of the generic law is not indicated at this time.

A-4303-Catania—HIV Testing. Requires that persons convicted of sexual crimes be tested for HIV sensitivity. **Active Support.**

A-4347-Mullen—Physician Assistants. Provides for the registration of physician assistants through a separate board. A supervising physician is necessary but does not need to be physically present at all times. **Active Opposition.** Registration of physician assistants neither will contribute to the quality of medical care nor decrease the cost of medical care and will create confusion in the health care delivery system.

A-4367 (ACS)-Bush—Medicare Assignment. Mandates acceptance of Medicare rates for seniors with incomes of $34,125 (single) and $41,875 (couple). **Active Opposition.** Unnecessarily favors wealthy seniors to the disadvantage of the middle class and the poor and is unfairly discriminatory against physicians.

A-4468-Pelly—Caller I.D. Requires free blocking services for call blocking for unpublished telephone numbers when caller I.D. is in place. **Active Support.**

A-4483-Rooney—Parental Notification for Abortion. Requires physicians to give an unemancipated minor's parent or guardian at least 48 hours notice prior to performing an abortion. **Active Opposition.** This legislation would interfere with the physician/patient relationship and drive young women to seek illegal abortions.

A-4585-Mullen—Nurse Practitioners. Authorizes nurses to diagnose and treat and to otherwise practice all licensed health professions. **Active Opposition.** Nurses are not qualified to make a medical diagnosis nor to prescribe therapeutic medications.

Senate/Assembly (Monitor)

S-804-Rice—AIDS. Requires hospitals to accept their fair share of AIDS patients. **No Action.**

S-1592-Cardinale—Fluoride. Prohibits the addition of fluoride to the water of adult psychiatric facilities that have independent water sources. **Approved.**

S-2282-Bassano—Anabolic Steroids. Classifies anabolic steroids as a "schedule V" drug. **No Action.**

S-2369-DiFrancesco—Rights of Psychiatric Patients. Guarantees rights of psychiatric patients in screening services and short-term care facilities. **No Action.**

S-2384-Paterniti—Rights of Psychiatric Patients (same as A-948). Guarantees rights of psychiatric patients in screening services and short-term care facilities. **No Action.**

S-2605-DiFrancesco—Occupational Therapy. Provides for the regulation and licensing of occupational therapists and occupational therapy assistants. **No Action.**

S-3034-Zane—HIV Testing (Marriage License). Requires HIV testing before issuance of a marriage license. **Disapproved.** Consenting adults should be able to voluntarily decide whether to be tested.

S-3053-Dalton—Blood Transfusion (same as A-4082). This bill establishes the "Blood Safety Act of 1990." The bill requires that if a blood transfusion is likely to be necessary during surgery, a physician or surgeon must inform his patient of blood transfusion options, that is autologous, designated, and homologous blood transfusions. The physician or surgeon then would note on the patient's medical record that all blood transfusion options have been explained to the patient prior to surgery. **Disapproved.**

S-3063-Van Wagner—Immunity. Provides that practitioners treating patients for certain conditions who become aware of the patient being a danger to a known third party must notify the third party or the police of that danger. Immunity is provided for such notification. **Approved.**

S-3086-DiFrancesco—Psychiatric Commitments. Defines rights of patients in psychiatric facilities and screening centers. **Approved.**

S-3090-Cafiero—Emergency Services. Provides that hospitals with an accredited EMS may apply to the New Jersey State Department of

Health to develop and maintain an intermediate life-support program with local squads under regulations adopted by the commissioner. **Action Deferred.** Pending further information from the Committee on Emergency Medical Care and the New Jersey Chapter, American College of Emergency Physicians.

S-3132-Codey—Health Insurance. Requires that health insurers must offer mini-health coverages. These coverages may not be offered to groups that had health coverage in the preceding 12 months. **No Action.**

S-3143-Ambrosio—Psychologists. Requires hospitals to permit psychologists to use hospital facilities on the same basis as physicians. **Disapproved.** Psychological services do not meet the severity of illness and intensity of service standards of acute care hospitals.

S-3211-Cowan—Health Insurance. Provides that health insurers must offer preventive health services. A cap is placed on the dollar value of the benefit service that expands with the consumer price index. **Action Deferred.** Pending further information from the Council on Public Health.

S-3225-Girgenti—PAAD. Requires that Pharmaceutical Assistance to the Aged and Disabled be revised in accordance with any social security increases that are cost of living based on an annualized basis. **Approved.**

S-3229-Paterniti—Regulatory Board Notices. Requires the New Jersey State Department of Health to forward reports on certain disciplinary matters it receives from licensing boards to the State Board of Pharmacy. **No Action.**

S-3265-Feldman—PAAD. Increases Pharmaceutical Assistance to the Aged and Disabled limits and ties future increases to social security cost of living adjustments. **No Action.**

S-3320-Haines—Psychiatric Hospitals. Creates a 13-member study commission regarding the long-term role of state psychiatric hospitals and developmental centers. Nine members are ex-officio, while four public members will be appointed by the governor. **Disapproved,** as this is unnecessary legislation.

A-732-J. Smith—AIDS. Requires isolation of patients with AIDS in state psychiatric hospitals. **Approved.**

A-948-Otlowski—Rights of Psychiatric Patients (same as S-2384). Guarantees rights of psychiatric patients in screening services and short-term care facilities. **No Action.**

S-2404-Baer—Sulfites. Prohibits sale of food or food products to which sulfites have been added. **Conditional Approval.** Pending removal of the exemption of manufacturers and growers from this bill and the addition of a labeling requirement.

A-3434-Deverin—Occupational Therapists. Provides for the licensing and regulation of occupational therapy. **No Action.**

A-4082-Roberts—Blood Transfusion (same as S-3053). This bill establishes the "Blood Safety Act of 1990." The bill requires that if a blood transfusion is likely to be necessary during surgery, a physician or surgeon must inform his patient of blood transfusion options, that is autologous, designated, and homologous blood transfusions. The physician or surgeon then would note on the patient's medical record that all blood transfusion options have been explained to the patient prior to surgery. **Disapproved.**

A-4161-Felice—Medicaid. Expands Medicaid to cover pregnant women and children up to six years of age when family incomes are 133 percent of the federal poverty level. **No Action.**

A-4177-Mecca—Mammography Technician. Creates a limited certificate for mammography x-ray technologists. **Disapproved.** There is no demonstrated need for licensure of this occupation as a separate and independent profession.

A-4223-Ford—Lyme Disease. Creates a nine-member Governor's Advisory Council. One of the governor's two appointments must be a physician. **Disapproved.** Unnecessary legislation.

A-4269-Mullen—HMO Business Practices. Prohibits home maintenance organizations from using "trans-o-grams" or other similar billing devices. **No Action.**

A-4301-Deverin—Health Insurance. Requires insurers to make available a basic plan for employers with fewer than 25 employees. **Approved.**

A-4333-Cimino—Health Maintenance Organizations. Requires HMOs to secure a certificate of authority from the New Jersey State Department of Insurance and otherwise transfer to the New Jersey State Department of Insurance regulatory jurisdiction over financial aspects of HMOs. **Approved.**

A-4351-Impreveduto—Tattoo Parlors. Authorizes the New Jersey State Public Health Council to regulate tattoo parlors. **Approved.**

A-4438-Felice—Emergency Volunteers. Requires the New Jersey State Department of Health to provide free vaccinations for hepatitis B to emergency volunteers. **Approved.**

A-4498-Farragher—Tuberculosis (TB). Permits a board of education to have new students tested for TB if there is no record of a Mantoux test. **Approved.**

A-4699-Brown—Smokers' Rights. Prohibits employers from taking certain actions, with respect to employees who smoke or use tobacco products. **No Action.** □

NEW MEMBERS

The Medical Society of New Jersey would like to welcome the following new members:

Bergen County
Barbara A. Cavallaro, MD
Philip J. Filippis, MD
Eugene S. Gorman, MD
Janet S. Levick, MD
Alan R. Miller, MD
Michael F. Scognamiglio, MD
Margaret A. Whelan, MD

Burlington County
Lawrence M. Ahr, MD
Leah Baron, MD
David D. Gross, MD
Vincent E. Guarini, MD

Camden County
Richard A. Isenberg, MD
Joseph L. Maccarone, MD

Cumberland County
Howard T. Gitter, MD
Rajendra M. Sharma, MD

Essex County
William J. Catena, MD
Stephen D. De Fronzo, MD
Paul V. Dell'Aquila, MD
Norman Holzberg, MD
Robert Picciano, MD
Michael A. Zimmer, MD

Gloucester County
Louis M. Petrozza, MD

Hudson County
Thomas E. Simpson, MD

Hunterdon County
Kenneth B. Blankstein, MD
Debra W. Curry, MD
Jean M. Golden-Tevald, DO
Keith T. Goldstein, MD
Robert C. More, MD
Irene A. Pedersen, MD

Mercer County
Sarfaraz Ahmad, MD
Steven E. Mazlin, MD
Susan N. McCoy, MD
Kathryn E. Morris, MD
John P. Nolan, Jr, MD
Robert M. Silverbrook, DO
Carlos C. Soriano, MD
James A. Webb, MD

Middlesex County
Mark S. Butler, MD
William P. Goldberg, MD
Glenn M. Grossman, MD
David A. Harwood, MD
Harold V. McKenna, MD
Beverly A. Poelstra, MD
Geza Ruszka, MD
Girija S. Surya, MD

Monmouth County
Marshall P. Allegra, MD
Elliot S. Grand, MD
Gregory G. Gunsten, MD
Rubin Kesner, DO
Edwin C. Leschhorn, MD
Alka P. Lothe, MD
Patrick P. Montefusco, MD
Herbert J. Rudolph, MD
Saad A. Saad, MD
Edward B. Wotycha, MD
Mary Yee, MD

Morris County
Kevin M. Barry, MD
Mark A. Blum, MD
Elliot A. Grossman, MD
Charles J. Marotta, MD
Naomi H. Miller, MD
Gerald Shapiro, MD

Ocean County
Scott E. Kemmerer, MD
Chi M. Wu, MD

Passaic County
Howard C. Adelman, MD
Cindy M. Breznak, MD
Azhagasundaram Ganesan, MD
Glenn R. Gangi, MD

Somerset County
Ronald H. Gonzalez, MD

Union County
Robert S. Falcone, MD
Donna J. Levy, MD
Howard M. Pecker, MD
Michael R. Zaboski, MD

PLACEMENT FILE

The following physicians have written to the executive offices of MSNJ seeking information on opportunities for practice in New Jersey. If you are interested in information concerning these physicians, we suggest you make inquiries directly to them.

Cardiology

George D. Birmingham, MD, 3531 Salerno Ct., Apt. 5, Middleton, WI 53562. Mount Sinai 1984. Board eligible. Board certified (IM). Group or partnership. Available.

Family Medicine

Vicente F. Franco, MD, 9362 Bay Colony Dr., Apt. 1S, Des Plaines, IL 60016. Universidad Central del Este 1982. Board eligible. Available.

Internal Medicine

Thomas P. Hooker, DO, 2804 Sitios St., Tampa, FL 33629. Philadelphia College of Osteopathic Medicine 1984. Board certified; also, PUL. Solo or multispecialty group. Available immediately.

Marc Kesselhaut, MD, 1 Rustic Ridge, C16, Little Falls, NJ 07424. St. George's University 1986. Board eligible. Solo or partnership in Mercer, Somerset, Burlington, Hunterdon, or Middlesex County. Available.

M. Stekelman, MD, P.O. Box 900, Hightstown, NJ 08520. BSAS (Argentina) 1959. Also, gastroenterology. Board eligible. Outpatient or ambulatory facility. Available.

Obstetrics/Gynecology

Dennis Tumbokonm, MD, P.O. Box 476, Kimball, WV 24853. University of the East. Board eligible. Solo. Available.

Pediatrics

Donna Churlin, MD, 55 Montgomery St., Bloomfield, NJ 07003. UMDNJ 1987. Board eligible. Partnership or group in central New Jersey (Essex, Union, or Morris counties). Available.

Sheryl S. Hertel, MD, 6205 Brogan Pl., St. Louis, MO 63128. St. Louis 1986. Also, internal medicine. Board eligible. Board certified (IM). Group. Available.

Radiation Oncology

Carol L. Kornmehl, MD, 133 Wyncrest Rd., Marlboro, NJ 07746. SUNY-Downstate 1984. Board certified. Group, partnership, solo. Available.

Surgery

Nichlas J. Dudas, MD, 915 Princeton Ave., Philadelphia, PA 19111. UMDNJ 1986. Board eligible. Group or partnership. Available.

ARE YOU MOVING?

If so, please send a change of address to *NEW JERSEY MEDICINE*, Medical Society of New Jersey, Two Princess Road, Lawrenceville, NJ 08648, at least six weeks before you move.

Name_____

Old Address_____

City_____ State_____ Zip_____

New Address_____

City_____ State_____ Zip_____

PHILADELPHIA HEART INSTITUTE

at Presbyterian Medical Center

Cardiology Update

designed for the physician and provides an intensive survey of the current status of clinical cardiology . . .

Wednesday, September 4, 1991 3:00-5:00 PM

Office Cardiology: Part I – Bedside Diagnosis of the Cardiac Patient

Moderator: Bernard L. Segal, M.D.

Patients will be presented with interesting physical findings. History taking, analysis of carotid and jugular pulse, precordial palpation, heart sounds and murmurs, and review of x-rays will highlight this program. Stethophones will be used at each seat so that the audience and panel may be able to hear and interpret these findings.

- *Case Presentations and Panel Discussions*
- *CME Credits**
- *No Registration Fee*
- *Call for Reservation 662-8627*

Scheie Auditorium
Presbyterian Medical Center
39th & Market Streets
Philadelphia, Pennsylvania 19104

The Philadelphia Heart Institute at Presbyterian Medical Center is an affiliate of the University of Pennsylvania.

**Presbyterian Medical Center designates this continued medical education activity for 2 credit hours in Category I of the Physicians' Recognition Award of the American Medical Association and the Pennsylvania Medical Society Membership requirement. Nine sessions, 18 credits.*

CONTINUING EDUCATION

MEDICINE

September

4 **Anaphylaxis**
10:30-11:30 A.M.—St. Mary's Hospital, Passaic
(AMNJ)

5 **Appropriate Fluid IV Ordering, Electrolyte and Fluid Balance, TPN**
12 Noon-1 P.M.—Community Medical Center, Toms River
(Community Medical Center)

9 **DRG/Cost Containment**
7-8 P.M.—Wallkill Valley General Hospital, Sussex
(AMNJ)

9 **Diabetes in Pregnancy**
1-2 P.M.—New Lisbon Developmental Center, New Lisbon
(AMNJ and NJDOH)

9 **New Developments in Emergency Medical Care**
7-8 P.M.—Wallkill Valley General Hospital, Sussex
(AMNJ)

10 **Uncompensated Care**
12:15-1:30 P.M.—John Fitch Plaza, Trenton
(NJDOH and AMNJ)

11 **Chronic Pain Management and Issues Related to Iatrogenic Addiction**
10:30-11:30 A.M.—St. Mary's Hospital, Passaic
(AMNJ)

11 **Integration of Research and Clinical Practice in the Management of Cancer**
All day—Englewood Hospital
(Englewood Hospital)

13 **Second Annual Meeting**
12 Noon-8 P.M.—Nassau Inn, Princeton
(American College of Cardiology, New Jersey)

13 **Update on Infectious Diseases**
9 A.M.-1 P.M.—Hoffman La Roche, Nutley
(AMNJ)

18 **New Developments in Emergency Care**
10:30-11:30 A.M.—St. Mary's Hospital, Passaic
(AMNJ)

18 **Pulmonary Grand Rounds**
11:30 A.M.-12:30 P.M.—Newcomb Medical Center, Toms River
(AMNJ)

19 **Diabetes-Related Cardiovascular Disease**
1-2 P.M.—James J. Howard VA/Op Clinic, Trenton
(AMNJ and NJDOH)

21 **Aging: A Changing Process**
8 A.M.-5 P.M.—Kessler Institute for Rehabilitation, West Orange
(AMNJ)

21 **Diagnosis and Surgical Management of Lacrimal Disorders: Ophthalmology Medical Conference**
All day—Englewood Hospital, Englewood
(Englewood Hospital)

24 **13th Annual Scientific Symposium**
8 A.M.-4 P.M.—Ramada Inn, Princeton
(New Jersey Society for Critical Care Medicine)

24 **Primary and Preventive Health Care Revisited**
12:15-1:30 P.M.—John Fitch Plaza, Trenton
(AMNJ and NJDOH)

25 **Dermatology Conferences**
6-9 P.M.—Rutgers Community Health Plan, U.S. Route 1, New Brunswick
(UMDNJ)

25 **Medicine and the Media**
9 A.M.-12 Noon—MSNJ Headquarters, Two Princess Road, Lawrenceville
(MSNJ and MSNJ Auxiliary)

26 **Head and Neck Cancers**
4:30-8:30 P.M.—Mercer Medical Center, Trenton
(AMNJ)

26 **Monoclonal Antibodies**
12 Noon-1 P.M.—Community Medical Center, Toms River
(Community Medical Center)

26-28 **Advanced Gynecological Surgery**
New York Hilton, New York
(Society of Gynecologic Surgeons)

27 **Critical Care and Bioethical Issues in Perinatal Health**
8 A.M.-4:30 P.M.—Holiday Inn, Jamesburg
(AMNJ)

27-28 **Pediatric Advanced Life Support**
All day—Shore Memorial Hospital, Somers Point
(AMNJ)

October

2 **Thyroid Diseases**
10:30-11:30 A.M.—St. Mary's Hospital, Passaic
(AMNJ)

2 **Sports Medicine Update**
8:30-12:30 P.M.—MSNJ, Lawrenceville
(MSNJ)

4-5 **Communication Enhancement Training Program**
All day—Marriott Seaview, Absecon
(MIIENJ)

4 **Physician Office Laboratory Workshop**
All day—Center for Health Affairs, Princeton
(American Society of Clinical Pathologists)

9 **Peptic Ulcer Disease**
10:30-11:30 A.M.—St. Mary's Hospital, Passaic
(AMNJ)

11 **Multiple Sclerosis**
12 Noon-1 P.M.—South Jersey Hospital System, Bridgeton
(AMNJ)

15 **Renovascular Occlusive Disease and Renal Failure**
6:15-7:15 P.M.—Overlook Hospital, Summit
(Nephrology Society of NJ)

19 **Diabetes-Related Cardiovascular Disease**
1-2 P.M.—VA Medical Center, Lyons
(AMNJ)

22 **Primary Care Directions**
12:15-1:30 P.M.—John Fitch Plaza, Trenton
(NJDOH)

WATCH FOR SPECIAL ISSUES

SPORTS MEDICINE
SEPTEMBER 1991

ADDICTION
NOVEMBER 1991

HOME HEALTH CARE
FEBRUARY 1992

MEDICAL BOOK COLLECTING
MAY 1992

UPDATE YOUR MEDICINE 1991-92: Wednesdays program (in its Eighteenth year) 7PM-9PM, Cornell-UMC Association of Practicing Physicians of NYH; $75.00 covers eight 2 hour sessions, transcripts, refreshments, and Category I CME credits. Check to "UYM," 445 East 69th Street, Olin 328. Course starts 9/25/91—Update Cardiology; 10/17/90—Update Gastroenterology. Coordinator Debora A. Laan (212) 746-4752; Director Lila A. Wallis, MD (212) 737-4444.

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The 7th Annual International Symposium on Acupuncture & Electro-Therapeutics will be held at Columbia University, School of International Affairs, 420 W. 118th St., N.Y. City, during October 17-20, 1991.

These meetings are co-sponsored by the International College of Acupunture & Electro-Therapeutics & its official journal, Acupuncture & Electro-Therapeutics Research, The International Journal (published by Pergamon Press & indexed in 15 major indexing periodicals, including Index Medicus), Heart Disease Research Foundation; NY Pain Center; Electrical Engineering Dept., Manhattan College; Nordic Medical Acupuncture Society (Scandinavia); Schmerz Therapeutische Kolloquium (West Germany); Japan Bi-Digital O-Ring Test Assn.; Accredited toward Acupuncture Certification to practice acupuncture. Eligible for AMA CME Cat. I credit (about 40 credit-hours for the Symposium).

For information on meetings or submission or presentations of papers, contact Symposium Chairman, Prof. Y. Omura, M.D., Sc.D., 800 Riverside Drive (8-I) New York, NY 10032 Tel: (212) 781-6262 (10 am to 10 pm 7 days a week) or (212) 928-0658, Co-chairman, Prof. A.W. Cook, MD (516) 877-1821, or Bro. Michael Losco (212) 920-0162.

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Gary Okum, M.D. *Harry Wollman, M.D.*
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23 **Geriatrics: Camouflaged Medical Illness**
10:30-11:30 A.M.—St. Mary's Hospital, Passaic
(AMNJ)

23 **Medical Education Conference**
8:30 A.M.-3:30 P.M.—Medical Society of New Jersey Headquarters, Lawrenceville
(MSNJ, NJ Association of Hospital Directors of Medical Education, UMDNJ, and AMNJ)

23 **Medication Awareness**
Howard Johnson, Secaucus
(Hudson County Medical and Pharmaceutical Societies)

24 **Anaerobic Infections**
12 Noon-1 P.M.—Community Medical Center, Toms River
(Community Medical Center)

PSYCHIATRY

September

5 **Multiple Sclerosis: Neurological and Psychiatric Manifestations**
12 Noon-1 P.M.—Carrier Foundation, Belle Mead
(Carrier Foundation)

12 **MRI and PET Scanning in the Evaluation of Alzheimer's Disease**
12 Noon-1 P.M.—Carrier Foundation, Belle Mead
(Carrier Foundation)

19 **HIV in a Psychiatric Hospital**
12 Noon-1 P.M.—Carrier Foundation, Belle Mead
(Carrier Foundation)

25 **Common Psychiatric Syndromes in Cancer Patients**
2:30-3:30 P.M.—Trenton Psychiatric Hospital, Trenton
(AMNJ)

25 **Dual Diagnosis: The Double Burden of Addiction and Psychiatric Illness**
All day—Carrier Foundation, Belle Mead
(Carrier Foundation)

October

3 **Asthma/COPD: Update for Psychiatrists**
12 Noon-1 P.M.—Carrier Foundation, Belle Mead
(Carrier Foundation)

10 **Alcohol, Suicide, and Depression**
12 Noon-1 P.M.—Carrier Foundation, Belle Mead
(Carrier Foundation)

17 **Group Therapy with Adult Children of Alcoholics**
12 Noon-1 P.M.—Carrier Foundation, Belle Mead
(Carrier Foundation)

23 **Bipolar Illness**
All day—Carrier Foundation, Belle Mead
(Carrier Foundation)

31 **Dual Diagnosis: An Update**
12 Noon-1 P.M.—Carrier Foundation, Belle Mead
(Carrier Foundation)

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Department of Medicine Grand Rounds
Wednesdays 8:30 a.m.-9:30 a.m.

Sept.-Dec. 1991

September 1991

September 4, 1991
PHARMACOLOGIC THERAPY AFTER MYOCARDIAL INFARCTION
William W. Parmley, M.D.
Professor of Medicine
Chief, Division of Cardiology
Moffett/Long Hospital
San Francisco, CA

September 11, 1991
GRANULOCYTE MACROPHAGE COLONY STIMULATING FACTOR (GMCSF)
John Nemunaitis, M.D.
Assistant Professor of Medicine
Division of Hematology & Oncology
Fred Hutchinson Cancer Center
University of Washington
Seattle, WA

September 18, 1991
Yom Kippur—No Grand Rounds

September 25, 1991
HEMODYNAMIC DERANGEMENT OF SEPSIS: THE PROBLEM AND SOLUTION?
R. Phillip Dellinger, M.D., M.Sc.
Associate Professor of Medicine
Director, Critical Care
Department of Medicine
Baylor College of Medicine
Houston, TX

October 1991

October 2, 1991
NSAIDS: MECHANISMS OF ACTION AND ADVERSE REACTIONS
William M. O'Brien, M.D.
Professor of Medicine
Division of Rheumatology
University of Virginia
Charlottesville, VA

October 9, 1991
GENE ACTIVATION AND CYTOKINES IN PULMONARY INFLAMMATION & FIBROSIS
John A. McDonald, M.D.
Professor of Medicine, Biochemistry and Molecular Biology
Mayo Medical School
Director of Research
Mayo Clinic, Scottsdale
Scottsdale, AZ

October 16, 1991
CARDIAC ELECTROPHYSIOLOGY AND IMAGING
Scott E. Hessen, M.D.
Assistant Professor of Medicine
Division of Cardiology, Hahnemann University
Charles C. Nydegger, M.D.
Assistant Professor of Medicine
Division of Cardiology, Hahnemann University
Steven P. Kutalek, M.D.
Assistant Professor of Medicine
Director, Clinical Cardiac Electrophysiology
Division of Cardiology, Hahnemann University

October 23, 1991
HLA-B27—PAST, PRESENT AND FUTURE
James Louie, M.D.
Professor of Medicine
Chief, Division of Rheumatology
Department of Medicine
Harbour-UCLA Medical Center
Torrence, CA

November 1991

November 6, 1991
TREATMENT OF HYPERLIPIDEMIA
David Bilheimer, M.D.
Professor of Medicine
University of Texas
Southwest Medical Center
Dallas, Texas

November 13, 1991
DIAGNOSIS AND TREATMENT OF BREAST CANCER
Isadore Brodsky, M.D.
Professor and Chairman
Department of Neoplastic Diseases
Hahnemann University
S. Benham Kahn, M.D.
Professor of Neoplastic Diseases
Department of Neoplastic Diseases
Hahnemann University

November 20, 1991
TREATMENT OF OSTEOPOROSIS
Robert Lindsay, M.D., Ph.D.
Professor of Clinical Medicine
Columbia University College of Physicians and Surgeons
Chief, Internal Medicine
Helen Hayes Hospital, NY

November 27, 1991
AIDS AND CARDIOVASCULAR COMPLICATIONS OF SUBSTANCE ABUSE
Vincent Zarro, M.D., Ph.D.
Professor of Medicine
Director, Division of Clinical Pharmacology
Hahnemann University

December 1991

December 4, 1991
DIASTOLIC MECHANISMS OF HEART FAILURE
Robert O. Bonow, M.D.
Chief, Nuclear Cardiology
Deputy Chief, Cardiology Branch
NHLBI, Bethesda, MD

December 11, 1991
THYROTOXICOSIS: A SPECTRUM OF DISEASE
Lewis E. Braverman, M.D.
Professor of Medicine and Physiology
Director, Division of Endocrinology
University of Massachusetts

December 18, 1991
IMMUNOLOGY AND RHEUMATOLOGY CLINICAL RESEARCH
Lawrence H. Brent, M.D.
Assistant Professor of Medicine
Division of Immunology and Rheumatology, Hahnemann University
Carolyn H. McGrory, R.N., M.S.
Clinical Nurse Specialist
Division of Immunology and Rheumatology, Hahnemann University

December 25, 1991
No Grand Rounds

Hahnemann University Department of Medicine
Wednesday Medical Seminar Series
8:30 a.m.-3:30 p.m.

September 25, 1991
SEPTIC SHOCK AND CRITICAL CARE

October 9, 1991
PULMONARY DISORDERS OF INFLAMMATION AND FIBROSIS

November 6, 1991
TREATMENT OF HYPERLIPIDEMIA

November 13, 1991
DIAGNOSIS AND TREATMENT OF BREAST CANCER

November 20, 1991
TREATMENT OF OSTEOPOROSIS AND METAGOLIC BONE DISEASE

Seminar Directors:

William S. Frankl, M.D.
Professor of Medicine and Chairman
Department of Medicine

Allan B. Schwartz, M.D.
Professor of Medicine
Director, Continuing Medical Education for the Department of Medicine

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IN MEMORIAM

LOUIS DELUCA

Family practitioner Louis DeLuca, MD, of Ridgewood died April 14, 1991. Dr. DeLuca was born in New York City on September 23, 1914. A Ridgewood physician for 46 years, Dr. DeLuca earned his medical degree from New York Medical College, New York, in 1938. After serving as a major in the United States Army, during World War II, Dr. DeLuca received his New Jersey medical license in 1945. During his career, Dr. DeLuca was affiliated with Valley Hospital, Ridgewood, and with Paterson General Hospital. Dr. DeLuca was a member of our Bergen County component and of the American Medical Association; a fellow of the American Academy of Family Practice; and a diplomate of the American Board of Family Practice.

LOUIS FEINSTEIN

Recipient of the MSNJ Golden Merit Award, Louis Feinstein, MD, of Margate, passed away on May 8, 1991, at the age of 84. Dr. Feinstein was born in Philadelphia, Pennsylvania, on April 1, 1907. He graduated with a medical degree from New York University School of Medicine, New York, in 1933 and received his New Jersey medical license one year later. A family practitioner, Dr. Feinstein practiced in Atlantic City and was an area resident for over 70 years. During World War II, Dr. Feinstein served as a captain in the United States Army. Dr. Feinstein was a member of our Atlantic County component and of the American Medical Association.

MILTON GREENBERG

Sixty-five-year old Milton Greenberg, MD, of Paramus, died on April 7, 1991. Dr. Greenberg was born in New York City on February 6, 1926. He attended Chicago Medical School, Illinois, earning his medical degree in 1955. The following year, Dr. Greenberg received his New Jersey medical license. Dr. Greenberg interned at Hackensack Medical Center. A family practitioner, Dr. Greenberg maintained a private practice in Paramus and was affiliated with Hackensack Medical Center and Bergen Pines County Hospital, Paramus. During World War II, Dr. Greenberg served in the United States Navy. Dr. Greenberg was a school physician for the Paramus school system; a member of our Bergen County component and of the American Medical Association; and a fellow of the American Academy of Family Practice.

PHILIP J. KUNDERMAN

Thoracic and cardiovascular surgeon, Philip John Kunderman, MD, died on March 30, 1991. Dr. Kunderman was born in New Brunswick on January 29, 1911; he attended Cornell University Medical College, New York, and received his medical degree in 1936. After completing an internship at Lenox Hill Hospital, and residencies at Cumberland Hospital and at Mount Morris Hospital, all in New York, Dr. Kunderman served in the United

States Army Medical Corps during World War II. In 1946, Dr. Kunderman received his New Jersey medical license. Dr. Kunderman was affiliated with Middlesex General Hospital, New Brunswick; Roosevelt Hospital, Edison; New Jersey Sanatorium for Tuberculosis, Glen Gardner; St. Peter's Medical Center, New Brunswick; Somerset Medical Center, Somerville; Muhlenberg Regional Medical Center, Plainfield; South Amboy General Hospital; Hunterdon Medical Center, Flemington; and Robert Wood Johnson University Hospital, New Brunswick. He maintained a practice in New Brunswick; was an associate professor of surgery at UMDNJ, New Brunswick; and past-president of the New Jersey chapter of the American College of Surgery. Dr. Kunderman was a diplomate of the American Board of Surgery; a fellow of the American College of Surgeons and of the American College of Chest Physicians; a member of our Middlesex County component, of the American Medical Association, of the New Jersey Society of Thoracic Surgery, and of the New Jersey chapter of the American College of Chest Diseases.

AUGUSTIN G. LATORRE

A member of our Hudson County component, Augustin G. Latorre, MD, died on April 24, 1991, at the age of 77. Dr. Latorre was born in Ecuador, South America, on May 12, 1913. Dr. Latorre earned his medical degree from Guayaquil University School of Medicine, Ecuador, in 1947. He completed a residency in psychiatry at Rockland Psychiatric Hospital, Orangeburg, New York, and an internship at St. Joseph's Hospital, New York. He received his Virginia medical license in 1967, and his New Jersey and New York medical licenses one year later. Dr. Latorre maintained a family practice in Ecuador, South America; New York City; and Union City. Dr. Latorre was attending at St. Mary Hospital, Hoboken. He was a member of the New York County Medical Society and of the American Medical Association.

JAMES M. MCDONOUGH

At the untimely age of 57, orthopedic surgeon James Michael McDonough, MD, died after a long illness, on May 2, 1991. Born in New Rochelle, New York, on April 15, 1934, Dr. McDonough lived in New York City before moving to Morristown where he maintained a private practice for 25 years. Dr. McDonough earned his medical degree from the University of St. Louis, Missouri, in 1960; and received his New York and New Jersey state medical licenses in 1961 and 1965, respectively. He completed an internship at St. Vincent's Hospital, New York, and residencies at St. Vincent's Hospital and New York Orthopedic Hospital, New York. Dr. McDonough was attending at Morristown Memorial Hospital; a diplomate of the American Board of Orthopedic Surgery; and a member of our Morris County component and of the AMA.

AUGUSTUS J. MCKELVEY

On April 10, 1989, Augustus John McKelvey died. Dr. McKelvey was born in New York City on May 25, 1904. He earned his medical degree from Columbia University College of Physicians and Surgeons, New York, in 1929 and received his New Jersey medical license in 1947. An internist, Dr. McKelvey

practiced in Millburn and was affiliated with the Hospital Center at Orange. He resided in Short Hills and retired to West Palm Beach, Florida. Dr. McKelvey was a member of our Essex County component, of the American Medical Association, and of the New Jersey Allergy Society. Dr. McKelvey served in the United States Army Medical Corps during World War II.

ROBERT H. MULLER

Montclair resident Robert Heyer Muller, MD, passed away on April 1, 1991. Born in Boston, Massachusetts, on November 10, 1921, Dr. Muller earned his medical degree from Columbia University College of Physicians and Surgeons, New York, in 1946. After receiving his New Jersey medical license in 1948, Dr. Muller served in the United States military until 1950. An internist, Dr. Muller was associate attending at The Mountainside Hospital, Montclair, director of employee health services at the hospital for 30 years, and a Montclair school physician. Dr. Muller was a member of our Essex County component and of the American Medical Association. He also maintained membership with the Medical History Society of New Jersey and with the American Association of the History of Medicine. Dr. Muller retired in 1987.

A. RONALD ROUSE

A. Ronald Rouse, EdD., passed away on July 12, 1991, at the age of 56. For the past 12 years, Dr. Rouse was the Director of Special Projects for the Medical Society of New Jersey. In this capacity, he coauthored a monthly column on professional liability and staffed several committees: Committee on Senior Citizens, Committee on Women in Medicine, Committee on Young Physicians, and the Task Force on AIDS. Before his affiliation with MSNJ, Dr. Rouse served as an elementary school teacher in Princeton and as a school principal in the Manalapan and Palmyra school systems. He also was an assistant professor of education at Rutgers University and Rider College. Dr. Rouse earned his master's degree at Trenton State College and his doctorate in education from Rutgers University. In 1965, Dr. Rouse was the recipient of a Fulbright Teachers Exchange Scholarship and taught in England for one year. A Trenton native, Dr. Rouse resided in New Hope, Pennsylvania, and Lambertville. He was a member of the Lambertville Board of Adjustment.

MORLEY P. WELLES

Born on September 27, 1914, in Brooklyn, New York, Morley Pitkin Welles, MD, passed away on April 29, 1991, at the age of 76. Dr. Welles attended Long Island College of Medicine, New York, earning his medical degree in 1944. He completed an internship at Brooklyn Hospital, New York, and a residency at Long Island University Hospital, New York. Dr. Welles maintained a private pediatrics practice in the Dover area for over 30 years, and was senior attending at Dover General Hospital and Medical Center and at St. Clare's Riverside Medical Center, Denville. Dr. Welles served in the U.S. Army as a captain during the Korean conflict. He was a member of our Morris County component and of the American Medical Association, and a school physician for the Randolph and Wharton school systems.

EDITORIAL CRITERIA

CONTENT

NEW JERSEY MEDICINE is the official organ of the Medical Society of New Jersey. The goals are educational and informational. All material published is copyrighted by the Medical Society of New Jersey.

The educational contents of each issue appear as scientific articles, based on research, original concepts relative to epidemiology of disease, and treatment methodology; case reports; review articles; clinical notes; state of the art reports; and special articles, that include evaluations, policy and position papers, and reviews of nonscientific subjects. Other topics include professional liability commentary; critical narration; medical history; pediatric briefs; nutrition update; and opinions. Editorials are prepared by the editor and by guest contributors on timely and relevant subjects. The Doctors' Notebook section contains organizational and administrative items from the Medical Society of New Jersey and from the community. Letters to the editor and book reviews are welcome and will be published as space permits.

The principal aim in the preparation of a contribution should be relevance to diagnosis and treatment and to the education of patients and professionals. Preference will be given to authors from New Jersey and to out-of-state lecturers submitting a suitable manuscript based on a presentation made to an audience in New Jersey.

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Submit two manuscripts that must be typewritten and double spaced on 8½" by 11" paper. Statistical methods used in articles should be identified.

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The author should submit a 30-word abstract to be used at the beginning of the article.

Tables must be typewritten and double spaced on separate 8½" by 11" sheets, with a title and number. Symbols for units should be confined to column headings, and abbreviations should be kept to a minimum.

Illustrations should be professional quality, black-and-white glossy prints. The name of the author, figure number, and the top of the figure should be noted on a label attached to the back of each illustration. When photographs of patients are used, the subjects should not be identifiable or publication permission, signed by the subject or responsible person, must be included with the photograph. Material taken from other publications must give credit to the source.

Generic names should be used with proprietary names indicated parenthetically or as a footnote with the first use of the generic name. Proprietary names of devices should be indicated by the registration symbol—®.

The summary of the article should not exceed 250 words; it should contain essential facts.

References should not exceed 35 citations except in review articles, and should be cited consecutively by numbers in parentheses at the end of the sentence. The style of *NEW JERSEY MEDICINE* is that of *Index Medicus:*

1. Goldwyn RM: Subcutaneous mastectomy. *NJ MED* 74:1050-1052, 1977.

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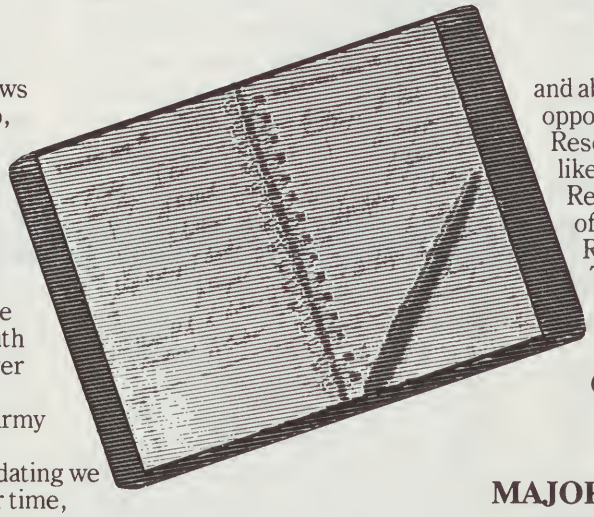
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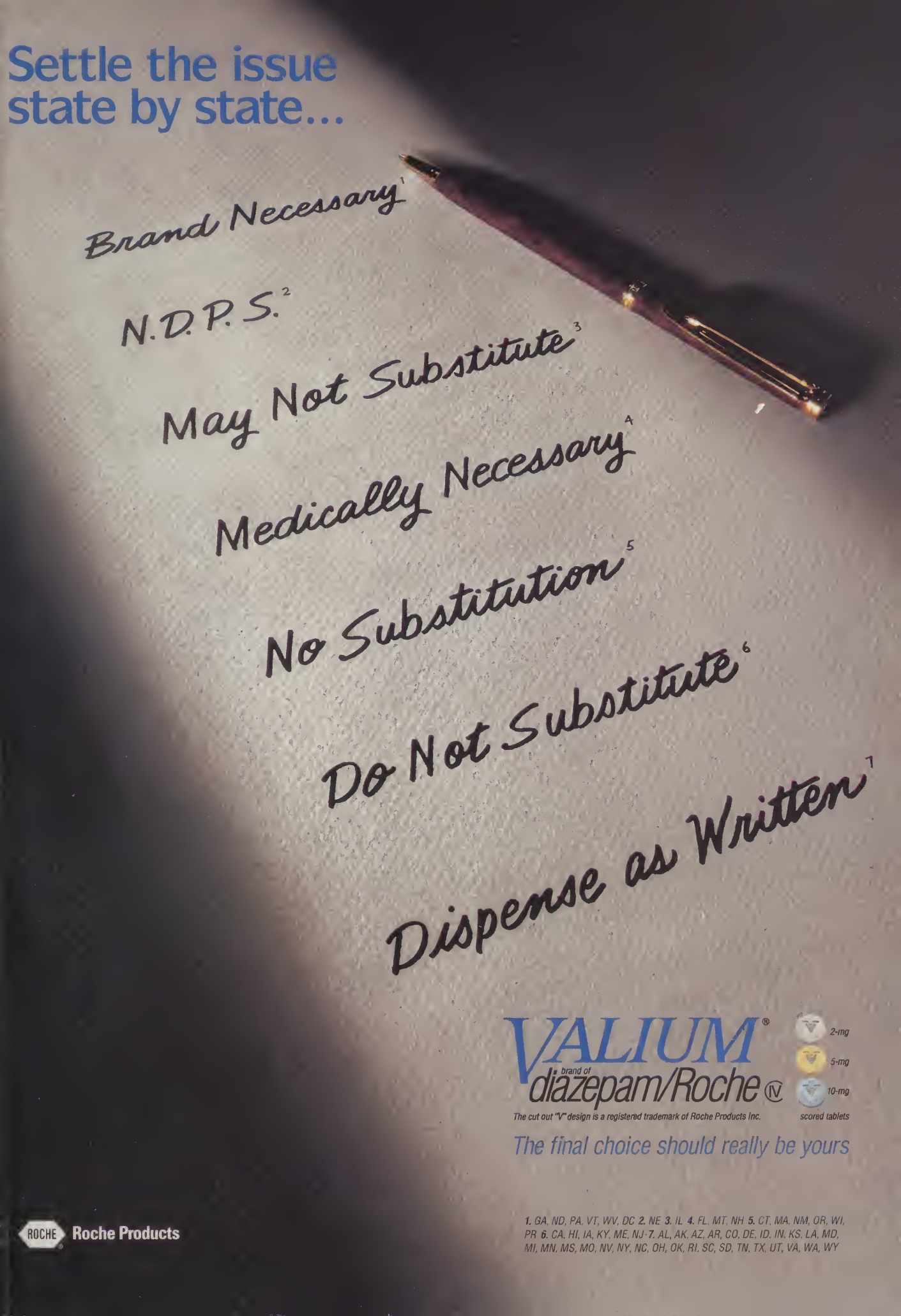
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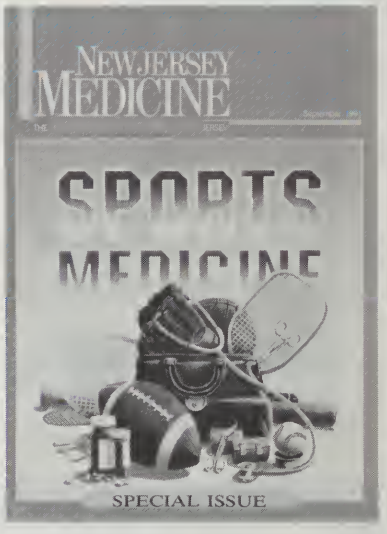
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The Cover

This issue brings to the practicing physician, the programs and concepts pertaining to sports medicine. Cover: Williams & Philips.



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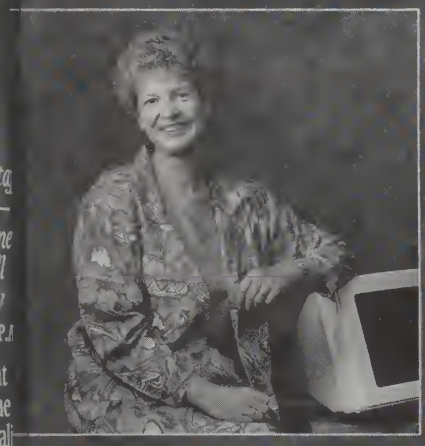


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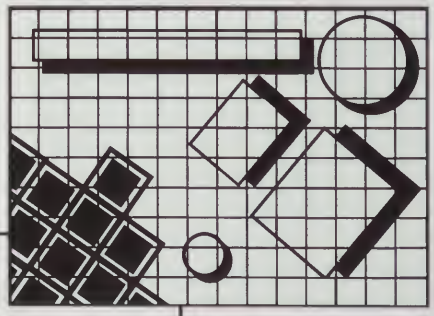
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POL WORKSHOP

A Physician Office Laboratory (POL) Workshop, sponsored by the American Society of Clinical Pathologists, will be held on October 4, 1991, at the Center for Health Affairs in Princeton. The program is open to medical personnel working in a POL and to physicians who would like to learn more about POL management. Program topics include: urinalysis, microbiology, blood collection and specimen preparation, CLIA regulations, and medical waste and OSHA regulations for POLs. The program is under the direction of Kathleen Voldish, the New Jersey state advisor to the American Society of Clinical Pathologists. To receive further information, contact Ms. Voldish at her Haddonfield office, 609/428-7652.

GLOBAL SURGERY PACKAGE

The equitable implementation of the physician fee schedule requires a national payment system with uniform policies and procedures. Accordingly, the Health Care Financing Administration (HCFA) has proposed a uniform, national global surgery policy that applies to all areas of the country and to all settings. Not only major surgeries, but minor and nonincisional procedures will come under the new policy.

Currently, surgeons bill a single, global fee for all services usually associated with a surgery, including preoperative visits, the operation, intraoperative services, and followup care. The definition of global services, however, varies significantly among Medicare carriers. For example, 53 percent of the carriers include preoperative services in the global fee. And while all of the carriers include postoperative care in most global fees, the number of days in the postoperative period varies from 0 to 270 days after surgery.

The proposed global surgery package standardizes policy on these issues. The initial evaluation or consultation to determine the need for surgery would be separately reimbursed. All other preoperative visits, from the time the decision to have the surgery is made, would be included. A maximum preoperative period of 30 days is proposed.

Conservative care rendered prior to the decision to perform surgery would be reimbursed separately, even if provided within the 30-day preoperative period. Similarly, services needed to stabilize a seriously ill patient before surgery will be paid separately. In these cases, documentation from the provider will likely be required.

The operation itself and related intraoperative services would be included in the global surgery package. A separate payment for complications would not be made for medical or surgical services required of the surgeon that do not require additional trips to the operating room. Return trips to the operating room, however, would be paid separately at reduced levels.

The global surgical fee also would include all postoperative visits by the primary surgeon within 90 days of the surgery. But this does not include visits for problems unrelated to the surgery.

For minor surgeries and nonincisional procedures ("scopies"), HCFA proposed that no visit generally be paid for by Medicare

in addition to the procedure unless a documented, separately identifiable service is furnished. Postoperative services related to recovery from the procedure would be included for a period of 30 days. Later this year, HCFA will publish a list defining those procedures that fall under these guidelines.

Medicare carriers will send informational notices to individual physicians who bill separately for postoperative visits that will be included in the new global package. However, the carriers will continue to pay for surgeries and related visits in accordance with their existing local policy.

Beginning January 1, 1992, the national global fee policy will go into effect for procedures performed on that day and later. Physicians will be hearing directly from their carriers concerning changes to coding requirements. ☐ Maurice Hartman, HCFA, Regional Administrator

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The Drug Registration section of the New Jersey State Department of Health (NJDOH) has informed MSNJ of the delay in mailing Controlled Dangerous Substance (CDS) Certificates of Registration that follow the timely submission of a CDS renewal application. NJDOH is engaged in processing the CDS renewal applications that bear an expiration date of June 30, 1992. Those practitioners who retained a copy of their renewal applications may use this copy to show that they have fulfilled their obligations in returning the renewal form. Those practitioners who failed to retain a copy of their renewal applications regrettably will have to wait an additional period of four to six weeks until NJDOH staff can manually alphabetize the returned renewal applications for ready accessibility. Until this process is completed, NJDOH cannot determine whether a practitioner returned his renewal application and, therefore, is unable to confirm current status. ☐ Al Ravin, RP, DC Coordinator, Drug Registrations.

NATIONAL IMMUNIZATION WEEK

Measles has become epidemic in New Jersey cities. In an effort to increase public awareness for the need for immunizations, especially among preschool-aged children, the American Academy of Pediatrics and the Children's Action Network have launched a campaign: National Immunization Week, September 21 to 29, 1991.

New Jersey has an opportunity to use the momentum of this campaign to influence families to obtain immunizations. Frances J. Dunston, MD, MPH, State Commissioner of Health, formed the New Jersey Coalition for Childhood Immunization requesting Atlantic City, Camden, East Orange, Elizabeth, Irvington, Jersey City, Newark, New Brunswick, Passaic, Paterson, Plainfield, and Trenton to form local coalitions. Participating in this effort will be health care providers, volunteer agencies, and foundations. Coalition leaders will contact physicians to expand their ability to provide immunizations: by ensuring that all patients are appropriately immunized for childhood diseases; by volunteering to serve at a site where immunizations are being offered to low-income families; and by encouraging families to enroll in a program that offers comprehensive child health care. ☐

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PROFESSIONAL LIABILITY

IN MEMORIAM

A. Ronald Rouse, EdD, of Lambertville died July 12, 1991, at Chandler Hall hospice in Newtown, Pennsylvania, at the age of 56. An integral part of this column, Dr. Rouse served as Director of Special Projects for the Medical Society of New Jersey for 12 years ending in January 1991.

MALPRACTICE VERDICTS

Defendant physicians prevailed before six of seven juries that reached verdicts in New Jersey medical malpractice cases.

The exception was a case involving a physician's alleged failure to test a 64-year-old patient for coronary heart disease prior to the patient's death. An instructor in handwriting analysis testified that the physician's notes of events occurring over a period of one and one-half years were written at a single time, despite the physician's contention that all notes were contemporaneous with the events.

In another case, a physician was credited with "a sincere and professional appearance" in testifying that he had not ignored signs of uterine infection before and after surgically removing an intrauterine device from the patient. The physician prevailed in court.

A cardiologist, charged with negligently failing to realize he had perforated a heart muscle during a biopsy, prevailed in a wrongful-death action. The defense asserted that the hole in question was created to withdraw fluid.

A 36-year-old childless woman with a history of prolonged menstrual bleeding received a hysterectomy that she later contended in court was unnecessary. According to the successful defendant, indications for the surgery included a hematologist's finding of a blood disorder.

Internists accused of failing to diagnose appendicitis in a 19-year-old woman were apparently helped by evidence that, after one of the internists advised the family by telephone to visit a hospital emergency department, the family instead traveled out-of-state to celebrate New Year's Eve. A jury found in the defendants' favor.

An orthopedic surgeon testified as an expert witness that the defendant surgeon was presented with a lipoma of a type that is difficult to remove entirely, due to intertwining of the lipoma fibers with normal fibers and the possibility that total removal can cause necrosis. The surgery on the patient's leg was performed for cosmetic reasons. The successful defendant contended that liposuction still could be performed to remove that portion of the lipoma that was not removed during the surgery.

An expert for the defense was permitted to perform an invasive procedure to determine whether a patient's possible incontinence was caused by the defendant urologist's alleged negligence in performing prostate surgery. The expert found scarring resulting from previous surgery. The jury brought in a verdict for the urologist.

Slips and falls on hospital grounds were at issue in two decisions. In Union County, an outpatient complained of soft-tissue cervical injuries after falling in a wet corridor, but she failed to recover in court. But, a jury in the same court found a hospital 60 percent negligent for maintaining uneven paving in a driveway where the plaintiff fell and fractured her ankle, allegedly after jaywalking.

AIDS ISSUES

The Centers for Disease Control's (CDC) long-awaited guidelines on HIV testing of physicians and other health care workers were published in *Morbidity and Mortality Weekly Report* on July 15, 1991. CDC recommended that health organizations and institutions should identify "exposure-prone" procedures, and that personnel who perform such procedures should learn their HIV status and, if that status is positive, cease performing exposure-prone procedures. The report noted that the only known case of practitioner-to-patient HIV transmission involved a dentist in Florida.

New Jersey's State Department of Health has proposed that mandatory reports of AIDS cases submitted to the Department include the patient's name and address. The use of identifiers may facilitate contact tracing and other preventive measures. MSNJ strongly supports the proposal.

A federal court in Minnesota denied the government's motion to throw out a claim involving a transfusion of HIV-infected blood. In 1983, a National Guardsman on active duty at Fort Benning, Georgia, received nine units of blood during an elective

procedure to treat diverticulitis. Three months later the Guardsman was married. In 1989, following his discharge from service, he and his wife's youngest child tested positive for HIV. Subsequently, both partners also tested seropositive.

The government argued that, under a rule known as the Feres doctrine, it is not liable for claims arising out of activity incident to military service. But, the court concluded that the rationales underlying the doctrine do not apply in the former Guardsman's case, because he is ineligible for veteran's benefits and because the surgery was not incident to military service (*C.R.S. v. United States*, 1991 U.S. Dist. LEXIS 5385, N.D. Minn).

"AIDS/HIV and Confidentiality: Model Policy and Procedures" is the title of a 122-page publication released by the American Bar Association. The publication focuses on disclosure of an individual's positive HIV status. To order, at a price of $28.95, call 202/331-2240.

LIVING WILLS AND ETHICS

On January 11, 1992, the New Jersey Advanced Directives for Health Care Act will take effect. The Act was signed by Governor Florio on July 11, 1991. The Act authorizes individuals to specify in writing the circumstances under which life-sustaining treatments should not be undertaken, in case of illness or injury. Under the legislation, individuals also may select someone to serve as a proxy in making decisions about life-sustaining treatments that the individual later is unable to make.

Captioned S-1211, the legislation was supported by a broad coalition of organizations that included the Medical Society of New Jersey (MSNJ). It was promoted by the State Commission on Biomedical Ethics. Robert L. Pickens MD, is chairman of the Commission and is a member of the MSNJ Committee on Bioethics.

By enacting the measure, New Jersey joins 48 other states in authorizing living wills by statute. Ironically, New Jersey's Supreme Court led the nation in judicial authorization of patients' and families' decisions to forgo life-sustaining treatments.

The American College of Physician Executives (ACPE), based in Tampa, has published an 86-page collection of essays entitled "The Higher Ground: Biomedical Ethics and the Physician Executive." Many of the concepts discussed, such as the relationship between medical and economic values, apply to private practice as well as institutional situations. ACPE also is sponsoring two separate week-long courses on physician leadership in Tempe, Arizona, in October. Subjects include health financing, technology assessment, and benefit-cost analysis. ACPE's telephone number is 813/287-2000.

LIABILITY TIPS

More than $41 million in malpractice payments for failures to diagnose colon cancer have been reported to the Physician Insurers Association of America. A slight majority of the 151 reported cases of malignant neoplasms of the large bowel involved patients younger than age 50. Physician liability resulted from alleged inattention to symptoms that included bleeding, changes in bowel habits, anemia, and weight loss. Many of the physicians found liable also did not obtain family histories.

Even without claiming any physical injury, a patient may collect emotional damages, the Illinois Supreme Court ruled. The unique precedent was set in a case involving a woman's lengthy sexual relationship with her therapist, an unlicensed psychologist. Speaking for the majority in the 5-1 decision, Justice Thomas Moran optimistically intoned: "Scientific research has provided modern society with a detailed and scientific understanding of the human mind," allowing juries "to fairly determine what is, and what is not, emotional distress."

By contrast, a Maryland circuit court judge dismissed a complaint filed by two Johns Hopkins Hospital patients who claimed emotional anguish from being treated by a surgeon who died of AIDS. Both the Illinois and Maryland decisions were summarized in the June 25 issue of *Medical Liability Monitor.*

An alcoholic surgeon who did not inform his patient of his alcoholism before performing a laminectomy was found liable for malpractice, and the judgment was affirmed by the Court of Appeal of Louisiana. The basis of liability was the lack of informed consent. Also at issue in the case was the surgeon's lack of disclosure of the risk of incontinence, which, according to an expert witness, occurs in 1 out of 200,000 cases, including this case (*Hidding v. Williams*, 1991 La. App. LEXIS 999).

MALPRACTICE POLICY DEVELOPMENTS

Senator Pete Domenici, a New Mexico Republican, has sponsored a proposed Medical Injury Compensation Fairness Act, requiring patients who file malpractice claims for federally insured care to abide by binding arbitration. All Medicare and Medicaid cases would be covered. Former Surgeon General C. Everett Koop, MD, collaborated with Domenici on the proposal.

A public opinion poll sponsored by the American Medical Association (AMA) and conducted by the Gallup Organization has revealed that people are more inclined than ever to view the medical profession overall in far more negative terms than they view their own physician. The widening disparity is labeled an "image gap." The evaluated behaviors include acting superior to other people, spending sufficient time with patients, and concentrating on making money.

In turn, physicians responding to another AMA survey rated professional liability as the main impediment to clinical decision making; second place went to utilization review.

In a May speech to the Physician Insurers Association of America, an official of the National Practitioner Data Bank announced the abandonment of plans to use the National Practitioner Data Bank to collect more information for research purposes. However, the Bush administration has proposed increasing the Bank's user fees.

PEER REVIEW LIABILITY

In a 5-4 decision in a case originating in California, the United States Supreme Court has permitted a physician dismissed from a hospital medical staff to sue the peer reviewers responsible for the dismissal (*Summit Health Ltd. et al. v. Pinhas*, 111 S.Ct. 1842, May 28, 1991).

In a significant liberalization of antitrust liability, the high court in the California case permitted the suit to rest on claims of anticompetitive behavior, without any claim of an effect on interstate commerce. In dissent, Justice Antonin Scalia argued that the decision "simply ignores the practical economics" of antitrust and confuses effects on a single competitor with effects on competition.

The decision follows, by three years, the high court's decision in *Patrick v. Butler*, which authorized suits against peer reviewers whose actions were not mandated by state law. Taken together, the two cases demonstrate the difficulty of crafting laws to immunize peer reviewers against liability. Retiring Justice Thurgood Marshall was in the majority in the Summit Health case, as part of a coalition in which Chief Justice William Rehnquist atypically aligned himself with the more liberal and modern wing of the court.

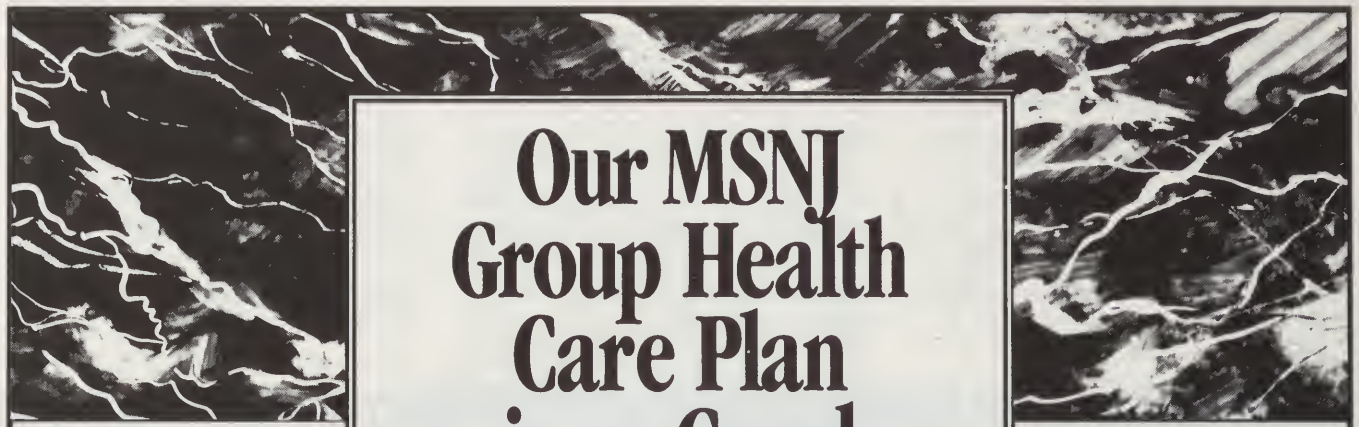
RATIONING

Health care rationing refers to explict efforts to allocate health services to individual patients on the basis of patient characteristics and/or the relative cost effectiveness of different services. The classic issue in rationing involves renal dialysis, which is reimbursed by Medicare. A committee of the prestigious Institute of Medicine, a branch of the National Academy of Sciences, has concluded that funding for the Medicare renal program should increase, even though many patients who receive the service are not strong candidates for survival.

In an example of the emotional appeal of the debate on rationing, *Private Practice* magazine termed rationing, "the bane of socialized health care systems in countries such as Canada, Sweden, and Great Britain." The statement appeared in an article on kidney treatments published in the periodical's July issue.

PROFESSIONAL LIABILITY

James E. George, MD, JD, and Neil E. Weisfeld, JD, MSHyg, prepared this commentary on behalf of the Department of Professional Liability Control of MSNJ. □



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BOOK REVIEWS

DISEASES OF THE NOSE, THROAT, EAR, HEAD & NECK

John Jacob Ballenger. Philadelphia, PA, Lea & Febiger, 1991. This is an excellent book, with complete coverage of the field of otolaryngology. A careful review reveals that for a quick reference on any subject, it serves as readily available. It certainly is not extensive enough for a resident in otolaryngology or for a practicing physician; however, for physicians in other specialties, such as family practice or internal medicine, and any physicians interested in otolaryngology, this book more than fulfills its task. I feel strongly that the book belongs on the shelf of almost any nonotolaryngological specialist.

The contributors to this volume are all experts in their particular field, thereby allowing the reader information from the leaders in otolaryngology.

Therefore, this book is unreservedly recommended for any physician or health professional who would like to have at his fingertips a very complete and updated review of otolaryngology as it is practiced today. ☐ Harold Arlen, MD

FEVER. BASIC MECHANISMS AND MANAGEMENT

PA Mackowiak. New York, NY, Raven Press, 1991. Sir William Osler reflected that "fever, famine, and war" are humanity's three greatest scourges. This book is one of the most clinically relevant textbooks for medical students and physicians. It is a book that brings together all new advances in the area of "fever." There are 20 chapters written by recognized authorities, containing remarkably up-to-date references and information. The chapters cover the basics of thermoregulation; the variety of endogenous and exogenous pyrogens; prostaglandins and their interaction with the development of fever; clinical thermometry; fever patterns as a clinical diagnostic tool; the immunological consequences of fever; fever of unknown origin; fever in the immunocompromised host; postoperative fever; fever in infants and children; fever in the elderly; heat stroke and other forms of hyperthermia as well as the pharmacokinetics and pharmacodynamics influenced by fever; and the treatment with antipyretics. One of the great clinicians of our time, Dr. Theodore Woodward, writes a delightful chapter of clinical pearls and caveats regarding the use of fever as a clinical diagnostic tool. Wonderfully detailed tables are offered in many of the chapters especially in the one entitled, "Fevers in the Immunocomprised Host," in which specific organisms are delineated in the relationship of timing to immunosuppressive agents, e.g. in renal transplant patients, chemotherapy, bone marrow transplant patients, heart transplant patients. A separate chapter is dedicated to fever of unknown origin with a superb delineation of the most common causes of fever of unknown origin with special precautions as well as clues in developing a diagnostic decision analysis tree using noninvasive and invasive techniques. The area of heat strokes and other forms of hypothermia is well delineated in a separate chapter, e.g. neuroleptic malignant syndrome, endocrine hypothermia, insulinoma, and pheochromocytoma crises as well as

"heat stroke." The chapter on "antipyretics" discusses animal models for screening the potency of a variety of agents, possible differential effects on prostaglandins release, and their uses in a variety of conditions. This text clearly is one of the more readable books on fever; the text has an extremely high clinically relevant value appropriate for any clinician. It is highly recommended for all medical students and clinical diagnosticians in the practice of medicine. ☐ Leonard Bielory, MD

MALIGNANT LYMPHOMA

Alan C. Aisenberg, MD, PhD. Philadelphia, PA, Lea & Febiger, 1991. Malignant Lymphoma: Biology, Natural History, and Treatment is comprehensive but not overwhelming; it is practical and unpretentious, and incisive and stimulating. Harvard's Dr. Alan C. Aisenberg provides his fellow clinical oncologists with an eminently readable discourse on the modern view of lymphoma and the complications of molecular biology and cytogenetics that are transforming our understanding of the pathophysiology of these disorders.

The author considers the clinical aspects of both Hodgkin's and non-Hodgkin's lymphomas, including classification and pathology, current approaches to management, and the roles of radiotherapy, chemotherapy, and bone marrow transplantation. Also discussed in this text are extranodal lymphomas, related disorders such as Castleman's disease, and the specific problems associated with Epstein-Barr virus and human immunodeficiency virus.

The presentation is succinct and straightforward and serves the reader by providing a fuller understanding of a complex and rapidly changing field.

A refreshing touch by Dr. Aisenberg is the emphasis provided by boldface type highlighting the text. It would have been better to see the mini atlas and other representations of histopathology in four color; black and white does not do justice to the images in the book. ☐ Alan J. Lippman, MD

PROGRESS IN CARDIOLOGY

Douglas P. Zipes, MD; Derek J. Rowlands, MD. Philadelphia, PA, Lea & Febiger, 1991. This is another in a series of "progress" texts designed to familiarize physicians with contemporary events in cardiology. This book is an eclectic mix of subjects related to transesophageal echocardiography, coronary artery disease, and congestive heart failure.

The section on transesophageal echocardiography is skimpy and, apart from the excellent figures, contributes little to the extensive literature already available for this exciting and relatively new technique. The chapter, "Coronary Artery Disease," is a rehash of such topics as cardiovascular actions of fish oils, management of patients after myocardial infarction, silent myocardial ischemia, and implications of the CAST study. Similarly, the chapter, "Congestive Heart Failure," deals with epidemiologic considerations, sudden cardiac death, and hormonal responses. These entities, of course, have been milked extensively in a variety of recent and remote publications.

There is very little in the text for the serious student of cardiology, but "progress" books may be of value for the busy practitioner who lacks the time or incentive to keep up with the ever-expanding flood of cardiac literature. On the other hand, the price of this text—$39.50—is disproportionate to the slender content of 138 pages. ☐ Edwin L. Rothfeld, MD



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EDITOR'S DESK



BE A SPORT

"Sports" is big business, and getting bigger all the time. The salaries of top athletes have reached semi-astronomical levels. Television coverage has expanded to cover all manner of "sports" at all hours of the day and night. Athletic prowess is considered the best way to insure an education and financial success. Children are removed from their families to train with prominent coaches. In this country, families dislocate themselves and parents retrain themselves to accommodate new climes for their precocious athletic children. Elsewhere, promising athletes exile themselves from their native lands; sometimes the entire family goes, sometimes just the athlete. "Big-time" coaches have salaries and perks that put the average academician to shame. Jocks and "average" students are not constrained by the same entrance and maintenance requirements.

The rewards for athletic stardom can be great. But the penalties for failure in this land of unlimited expectations can be similarly great, with the loss of time, effort, and life. "Big-time" athletics puts a wholesome family life, excellent educational standards and integrity, respect for contractual obligations, and a proper level of self-esteem (as opposed to mere egotism) under pressures severe enough to bend or break them. Too many participants and parents are not prepared to accept athletics for its own intrinsic value; only the potential for financial security is real.

Fortunately, many more people enjoy participation in sports for other reasons. Modern society has more leisure time and much of it is spent on fitness programs, many involving sports, as well as aerobics and other types of exercise. Glowing health can be its own reward, but there also is beauty and grace of athletic endeavors to delight both the performer and the beholder. The spirit of competition also can be long lasting, fulfilling, and elevating. Witness the growth of masters-type, older-age competitions, Special Olympics, and the like. Golf, tennis, swimming, and running are enjoyed by all ages and by those of varying degrees of proficiency and ability. Octogenarians run in marathons and as more run, there will be more octogenarians. Women have taken their rightful place in the world of sports, although many women golfers might disagree with the male-oriented philosophy of the (stereo) typical country club.

We are indebted to Doctors Paul Hirsch and Vincent McInerney and their contributors for this special issue. We hope you find it informative and entertaining. Medicine has changed dramatically through the years; there was no discipline known as "sports medicine" when I was a resident. Simple sprains or ligamentous tears were not subjected to any operation, but to casting. Arthroscopy was more of a dream than a reality. It took no special training or talent to be a team physician. Women were advised to play with dolls and to prepare for "women's work." Olympians and tennis players were amateurs, sometimes receiving a pittance under the table. Yes, times have changed. Is it for the better? □ Howard D. Slobodien, MD

> In America, it is sport that is the opiate of the masses. Russell Baker, "Observer," *The New York Times*, Oct. 3, 1967.

GUEST EDITORIAL: SPORTS MEDICINE

The phrase, "sports medicine," appears frequently in the press, in newspapers, in magazine articles, and in daily conversation. Many patients often want a sports medicine doctor although they may not know what this means. Indeed, sports medicine is a poorly defined area, cutting across many specialty lines. Most physicians treat sports-related problems within their specialties and, therefore, are sports medicine doctors. However, sports medicine also has come to signify and encompass the best that medicine has to offer, and the promise of rapid return to function after injury.

Our objective in this special issue is to bring to the practicing physician, the programs and concepts of those with a special expertise in a particular area of medicine, as pertaining to sports and exercise.

We are grateful to our contributing authors. Their ideas, their programs, and their suggestions will be helpful in our daily practices. We appreciate the encouragement and guidance of Geraldine R. Hutner, executive editor, whose hard work and understanding have made this issue possible. □ Paul J. Hirsch, MD, and Vincent K. McInerney, MD, Guest Editors

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4. Short-term treatment of **active, benign gastric ulcer**. Most patients heal within six weeks and the usefulness of further treatment has not been demonstrated.
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In active duodenal ulcer; active, benign gastric ulcer; hypersecretory states; and GERD, concomitant antacids should be given as needed for relief of pain.
CONTRAINDICATIONS: Zantac® is contraindicated for patients known to have hypersensitivity to the drug.
PRECAUTIONS: **General**: 1. Symptomatic response to Zantac® therapy does not preclude the presence of gastric malignancy. 2. Since Zantac is excreted primarily by the kidney, dosage should be adjusted in patients with impaired renal function (see DOSAGE AND ADMINISTRATION). Caution should be observed in patients with hepatic dysfunction since Zantac is metabolized in the liver.
Laboratory Tests: False-positive tests for urine protein with Multistix® may occur during Zantac therapy, and therefore testing with sulfosalicylic acid is recommended.
Drug Interactions: Although recommended doses of Zantac do not inhibit the action of cytochrome P-450 enzymes in the liver, there have been isolated reports of drug interactions that suggest that Zantac may affect the bioavailability of certain drugs by some mechanism as yet unidentified (eg, a pH-dependent effect on absorption or a change in volume of distribution).
Pregnancy: ***Teratogenic Effects: Pregnancy Category B***: Reproduction studies have been performed in rats and rabbits at doses up to 160 times the human dose and have revealed no evidence of impaired fertility or harm to the fetus due to Zantac. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.
Nursing Mothers: Zantac is secreted in human milk. Caution should be exercised when Zantac is administered to a nursing mother.
Pediatric Use: Safety and effectiveness in children have not been established.
ADVERSE REACTIONS: Headache, sometimes severe, seems to be related to Zantac® administration. Constipation, diarrhea, nausea/vomiting, abdominal discomfort/pain, and, rarely, pancreatitis have been reported. There have been rare reports of malaise, dizziness, somnolence, insomnia, vertigo, tachycardia, bradycardia, atrioventricular block, premature ventricular beats, and arthralgias. Rare cases of reversible mental confusion, agitation, depression, and hallucinations have been reported, predominantly in severely ill elderly patients. Rare cases of reversible blurred vision suggestive of a change in accommodation have been reported.

In normal volunteers, SGPT values were increased to at least twice the pretreatment levels in 6 of 12 subjects receiving 100 mg qid intravenously for seven days, and in 4 of 24 subjects receiving 50 mg qid intravenously for five days. There have been occasional reports of hepatitis, hepatocellular or hepatocanalicular or mixed, with or without jaundice. In such circumstances, ranitidine should be immediately discontinued. These events are usually reversible, but in exceedingly rare circumstances death has occurred.

Blood count changes (leukopenia, granulocytopenia, thrombocytopenia) have occurred in a few patients. These were usually reversible. Rare cases of agranulocytosis, pancytopenia, sometimes with marrow hypoplasia, and aplastic anemia have been reported.

Although controlled studies have shown no antiandrogenic activity, occasional cases of gynecomastia, impotence, and loss of libido have been reported in male patients receiving Zantac, but the incidence did not differ from that in the general population.

Incidents of rash, including rare cases suggestive of mild erythema multiforme, and, rarely, alopecia, have been reported, as well as rare cases of hypersensitivity reactions (eg, bronchospasm, fever, rash, eosinophilia), anaphylaxis, angioneurotic edema, and small increases in serum creatinine.
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PRESIDENT 'S PAGE

WOMEN IN ORGANIZED MEDICINE: SIDE BY SIDE

An article appeared in the July 24, 1991, edition of *JAMA* entitled "Gender Disparities in Clinical Decision Making." The article supports concerns that women are disadvantaged because of inadequate attention to the research, diagnosis, and treatment of women's health care problems.

Some researchers attribute a lack of research to women's reproductive cycles, to a reluctance to carry out studies on women of childbearing age, and to apprehensions that experimental treatments may affect reproductive capabilities.

Three areas were identified in which gender disparities exist: diagnosis of lung cancer; diagnosis and treatment of cardiac disorders; and access to kidney transplantation.

Despite this evidence, women receive more health care services overall than men; women have more physician visits per year than men; women undergo more examinations and laboratory tests than men; and women receive more drug prescriptions than men.

Unfortunately, some physicians are more likely to attribute women's health care complaints to emotional rather than physical causes. Women are perceived as tending to report their complaints to physicians earlier than men do, indicating an "over-anxiousness" about their health.

What does this mean, and what can we do about it?

1. Physicians should examine their attitudes and practice habits and eliminate any social, cultural, or gender bias affecting the health care of women.

2. Researchers must focus on disorders and conditions unique to women, more prevalent in women, and more serious in women. They must examine more thoroughly the major causes of death, disability, and frailty in women: cardiovascular disease, cancer, osteoporosis, and menopausal conditions.

3. All medical students, both male and female, must be trained to understand the physical differences and similarities between the sexes, and to be sure to listen to their patients and take their complaints seriously.

4. Attempts should be made to increase the number of female physicians in organized medicine, leadership roles, research, and other positions of authority.

What is the Medical Society of New Jersey doing to encourage participation of female physicians?

1. On June 23, 1991, MSNJ issued a news release asking all physicians in New Jersey to "reexamine their practice patterns to assure full sexual equality. Every physician in New Jersey must assure that no patient receives inadequate attention or insufficient diagnosis or treatment for reasons of gender." Physicians must be especially careful that women's health care problems are not sloughed off as "trivial" or "emotional" complaints.

2. MSNJ must promote the elevation of women to leadership roles in organized medicine. A working group on women in medicine has been established, the purpose of which is to get those women who are members more involved, and to get those women who are not members to join.

3. There are 4,298 women physicians licensed to practice medicine in New Jersey. Only 727 women physicians (approximately 17 percent) are members of MSNJ, and only 942 women physicians (approximately 21 percent) belong to the AMA. Through county societies and specialty organizations, we plan to initiate one-on-one contacts with all women physicians, with the hope that they will become part of the team. We want them to realize that we share their concerns and need their participation.

4. We hope to emphasize membership benefits for women, including life and disability insurance and financial planning services.

5. We plan to get more involved in women's health care issues such as mammography screening, teenage pregnancy programs, and the sharp increase in AIDS among women.

It appears quite inappropriate to practice medicine on a daily basis, side by side, with women physicians who may not belong to the decision-making organizations like county and state medical societies. Working together—side by side—is good. Meeting together—side by side—is even better. Let's do it! God bless. □ Joseph A. Riggs, MD

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The Athletic Team Physician's Medical Bag

Alan Cabasso, MD

Physicians are called upon to provide sideline coverage for athletes, as well as to travel with the team. The physician must be equipped with tools to handle a wide array of problems. The bag's contents allow the physician to manage medical, surgical, and orthopedic problems.

As more physicians are called upon to travel with athletic teams, the necessity of having a well-equipped medical bag is evident. Team physicians, whether trained in orthopedics or primary care, are called upon to provide comprehensive care to athletes in a variety of venues. These venues may be distant from medical facilities. Thus, the ability to provide emergency care, as well as routine care, should be taken into consideration when stocking the bag.

The contents of the medical bag would include those items that will allow the team physician to manage medical, surgical, and orthopedic problems. The bag would include equipment as well as pharmacological agents. Athletic trainers frequently accompany the physician and much of the equipment is contained within their bags.

The selection of items a physician may choose would be influenced by the sport as well as the medical problems of the athletes. The comfort and training of the physician with certain procedures and pharmacologic agents also would be a factor. The physician should be aware of drug testing and banned substances when stocking the bag.

THE MEDICAL BAG

The bag should be lightweight, sturdy, lockable, waterproof, and portable; it also should have several compartments. Size will be dictated by the needed contents, but the bag should be small enough to qualify as carry-on luggage on any airplane. A list of items for the medical bag are noted on the following page.

Medications carried by the team physician should include those agents that will help manage most common medical, musculoskeletal, and emergency problems. The physician should be aware of any banned substance list if testing is being performed. A prescription pad is necessary.

Additionally, dependent upon the event's locale, availability of ambulances, and the type of athletes involved, provisions for beginning advanced life-support may become necessary. ■

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Equipment for the Medical Bag

Diagnostic Equipment

- Standard penlight (with fresh long-life battery)
- Otoscope/ophthalmoscope set (battery-powered)
- Stethoscope
- Sphygmomameter
- Thermometer (oral and rectal)
- Reflex hammer
- Tape measure
- Tongue blades

Airway Management Equipment

- Airways (oral size: 3-6; nasal sizes: 26, 28, 30)
- Pocket mask
- Endotracheal tubes (sizes 6.5 to 8.0) with stylet and holder
- Nasal tampons for nosebleeds
- Laryngoscope (fresh batteries; 1 curved blade and 1 straight blade)
- Syringe (10 cc)
- Lubricant (disposable packs)

Orthopedic Equipment

- Elastic bandages (2″, 3″, 4″, 6″)
- Adhesive tape (1/2″, 1 1/2″)
- Slings (medium and large)
- Finger splints, alumafoam (1/2″ x 9″)
- Plaster
- Splint (fiberglass kit)
- Cast padding
- Nonsterile gloves
- Felt/foam variety packs
- Moleskin
- Orthoplast sheet
- Tape adherent (1 can)
- Bandage scissors
- Tape

Surgical Equipment

- Sutures (assorted absorbable and nonabsorbable, 4-0, 5-0, 6-0)
- Suture kits (disposable)
- Scalpels (disposable 11 gauge)
- Steristrips (1/4″, 1/8″)
- Sterile gloves
- Needles (18, 22, 25)
- Syringes (assorted, TB, 3, 10, 50)
- Sterile saline irrigant
- Lidocaine (1 percent vial)
- Betadine swabs
- Nail clipper

Eye Care

- Irrigating solution (eye wash)
- Eye patch
- Visine® or Murine®
- Contact lens lubricating solution
- Sulfacetamide ophthalmic drops

Miscellaneous

- Alcohol swabs
- Benzoin swabs
- Betadine swabs
- Bandages (assorted sizes)
- Cotton-tipped applicators
- Gauze pads (4″ x 4″, 2″ x 2″)
- Heavy duty ice bags
- Sling (3″)
- Intravenous saline (liter bag of Ringer's lactate with tubing, 50 percent dextrose vial)
- Swiss army knife

Analgesics

- Acetaminophen (500 mg tabs)
- Acetaminophen with codeine
- Meperidine HCl disposable cartridge-needle unit

Antibiotics

- Ampicillin® (500 mg)
- Cloxacillin® (500 mg)
- Erythromycin® (500 mg)
- Penicillin® V (500 mg)
- Polymyxin® B (Neomycin®, hydrocortisone otic suspension)
- Septra® DS or Ciprofloxacin®
- Acyclovir (200 mg)

Anti-Inflammatory

- Ibuprofen (600 mg tabs)

Allergy-Related and Cold Medicines

- Albuterol inhaler
- Diphenhydramine (25 mg capsules)
- Epinephrine 1:1000 (0.3 mg automatic injection)
- Terfenadine (60 mg tablets, antihistamine without drowsiness)
- Long-acting nasal spray (Afrin®)

Gastrointestinal/Antiemetic

- Antacid/simethicone tablets
- Loperamide® capsules
- Senokot-S® tablets
- Trimethobenzamide HCl disposable syringe 2 cc

Dermatologicals

- Vaseline®
- Hydrocortisone cream (1 percent)
- Clotrimazole cream
- Betadine or Bacitracin® ointment
- Acyclovir ointment

Anticonvulsants

- Valium® (10 mg, prefilled syringe)

Life-Support Items

- Epinephrine 1:10,000 (2 mg prefilled syringe)
- Sodium bicarbonate (50 mg prefilled syringe)
- Lidocaine (100 mg, vial)
- Atropine (2 mg prefilled syringe)

Extras

- Air cast (l left and 1 right)
- Air splints (1 set)
- Cervical collar (not foam type)
- Crutches
- Knee immobilizer
- Spine board
- Stretcher

Dr. Cabasso is director, Pediatric Ambulatory Care, Jersey Shore Medical Center. Requests for reprints may be addressed to Dr. Cabasso, Jersey Shore Medical Center, 1945 Corlies Avenue, Neptune, NJ 07753.



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The Sports Preparticipation Evaluation

Richard M. Ball, MD

The best sports preparticipation program requires an initial comprehensive evaluation, interim care, central reporting, and an appropriate followup examination. The preparticipation examination, when properly carried out, can meet the needs of our adolescents.

Anyone seeking a consensus on requirements, standards, protocols, and conduct of sports preparticipation medical evaluations for young athletes faces a formidable task. Much has been written on this subject by authorities in various disciplines, with widely divergent opinions. Even the very need for these examinations—loosely called sports physicals—has been questioned, largely because teenagers generally are healthy and because the yield of potentially disqualifying conditions is low, under 1 percent in some series.[1,2] A reliable incidence of disqualification is unknown, and it depends on the quality of the examination, ranging from perfunctory to meticulous.

I have attempted to find some common ground among the disparate practices and recommendations of sports medicine specialists, and synthesize these ideas into an updated, pragmatic state-of-the-art program.

LEGAL REQUIREMENTS

The preparticipation evaluation, comprising a medical history, physical examination, and recommendations for participation on some level, is a legal requirement by most states for school-sponsored competitive sports. The results of a survey of 45 states noted the following: 35 states require evaluations, with frequencies varying from unspecified to once every three years; not all of these 35 states require that a physician conduct the examination; and none of these 35 states requires that the examiner have any special training or expertise.[3]

New Jersey law (N.J.A.C. 6:29-6.4) requires annual examinations by a licensed physician not more than 60 days prior to the first seasonal practice, no matter how many different sports are played. This is in addition to routine preschool, nonsports-related health checkups.

PURPOSE AND GOALS

The primary purpose of the preparticipation examination, other than to satisfy legal or insurance mandates, is to identify any risk factors for injury or death. Although not all sudden deaths of young athletes are preventable, most injuries to players who participate beyond their physical limitations can be prevented.

Secondary goals of the preparticipation examination include identification of weaknesses, handicaps, and disqualifying conditions and their correction, if possible; diagnosing untreated illnesses and injuries; and determining levels of conditioning, fitness, and maturity. Some youngsters are determined to play a sport for which they are not physically suited. They should be steered toward less strenuous sports within their potential.

Finally, the preparticipation examination affords an opportunity for counseling children in nonathletic health-related topics as sex, drugs, alcohol, and mental health.

Those sports with the greatest risk for injury for men, in decreasing order of severity, are football, basketball, soccer, wrestling, and track; for women, the sports with the greatest risk for injury are gymnastics, track, and soccer.[4-6] As one might expect, these are the most popular sports. The goal should be participation at an appropriate level for almost all students.

These objectives will not be met if a pro forma preschool physical is accepted in place of a comprehensive, sports-oriented evaluation. The sports evaluation may satisfy the requirements of the preschool health examination, but not vice versa. Unfortunately, such a routine health examination often is the extent of the evaluation, usually at the last minute because the athlete cannot start practice "without a doctor's note."

TIMING AND FREQUENCY

The frequency of preparticipation examinations ranges from before every sport season, which for some athletes might be three times a year (clearly unnecessary and expensive), to once every three or four years, which probably is too infrequent. The American Academy of Pediatrics recommends a complete examination every two years.[7] State and local school district regulations usually determine this decision; however, that usually means annually, just after summer recess or before mid-summer scrimmages.

The very first examination, with a complete history, physical, and baseline performance studies, is the most important one, and should be of the highest caliber. Annual followup examinations may be limited to an interval history of illnesses and injuries, reexamination only of injured areas, measurements of height, weight, and blood pressure, and a flexibility and endurance test by the trainer or coach. The school's health office and athletic department should get written reports of any interval treatment for the student athlete's health record; indeed, this data gathering may be more important than doing an annual physical. Whatever its content, the examination ideally should be done about four to six weeks before practice begins to allow time to correct any treatable conditions.

DOING THE EVALUATION

The conventional wisdom is that the athlete's primary care physician is best suited performing the preparticipation examination. This probably is true; at least this physician has the youngster's complete history, an indisputable advantage. But physicians who have no interest in doing preparticipation examinations or who lack expertise in athletic medicine may overreact to abnormalities by interdicting all sports. In such a situation, the disappointed young athlete and his parents should consider obtaining a copy of the medical record and seeking a sports medicine specialist, one to whom the athlete might return in case of later injury. Another approach is for the primary care physician to do the general medical and cardiovascular examination and refer the patient to a specialist for the musculoskeletal examination. The problems with this plan are two appointments, two medical records, and two doctor bills.

Too often, youngsters have no regular physicians. Their families seek episodic care from emergency rooms or freestanding walk-in facilities, both inappropriate for preparticipation examinations. They do not have the youngster's history, will unlikely be a source of continuing care, and tend to be disease-oriented. Preparticipation examinations are a preventive medicine paradigm.

Mass Screening. The alternative to doctors' offices or medical centers is a facility that does mass screening, often the school itself. In contrast to the lack of consensus on other aspects of preparticipation examinations, there is virtual unanimity among sports experts in condemning the locker-room lineup, assembly-line herd approach. It is impersonal, history usually is missing or ignored, proper counseling rarely occurs, and the setting poses high risks for both examiners and examinees.

This should not be confused, however, with the widely accepted "group" or "station" method described by Garrick.[8] Suitable for a large number of examinations, athletes pass through dedicated stations staffed by nurses, physicians, and therapists or trainers who can do performance testing. History forms are completed in advance by the student and parents and reviewed by a nurse, who flags problem areas for the physician examiners. It is cost effective and efficient if organized by a team of interested health professionals with the necessary resources. Interestingly, the yield from such large group examinations tends to be influenced by the examiners' specialties.[1,2]

Table. ***Critical elements of a sports history.***

- Episodes of loss of consciousness or frequent headaches
- Head injuries seen by physician
- Syncope with exercise
- Fractures and dislocations
- Injuries treated by physician, especially knee or ankle
- Heat stroke, heat exhaustion, or frostbite
- "Hitting the wall"
- Hypertension
- Sudden death of blood relative under 50 years of age
- Hospitalization for surgery or medical illness
- Recent (past year) illness lasting longer than a week
- Chronic medical problems
- Missing organs (except tonsils and appendix)
- Prior restrictions from sports
- Current medical care, if any
- Current drugs—prescribed, over the counter, or recreational
- Contact lenses, hearing aids, orthoses, and prostheses

THE MEDICAL HISTORY

Like every other medical problem, history is paramount. Indeed, the history and the musculoskeletal examination are the two most important compo-

nents of the preparticipation examination.[2] The history should focus on those aspects relevant to participation in strenuous activities. Some critical elements of a sports history are shown in the Table.

PHYSICAL EXAMINATION

The athlete's parent should be available—but not present during the actual examination—to give further history, if needed, and to discuss all findings.

Particular attention should be directed to the cardiovascular and musculoskeletal examination, since the the highest yield of high-risk abnormalities will be found in these two systems.[9,10] Undiagnosed hypertension is the most frequently reported new finding at sports examinations.[11]

Cardiovascular. A history of exertional syncopal attacks or sudden death of family members under 50 should prompt a detailed family history. A family history of early onset of heart disease, infarction, hypertension, stroke, and obesity should be sought. If the athlete smokes, is overweight, has poor dietary habits, or has signs of a juvenile type-A personality, the cardiac examination should be more extensive. Repeated blood-pressure measurements and pulse rates might be coupled with simple tests of cardiac recovery after exercise.

Although many arrhythmias in this age group are benign, premature ventricular contractions (PVC), especially if they appear with exercise or persist into the rest phase, are indications for a cardiology consultation, not merely an electrocardiogram (ECG).

Diastolic murmurs, or grade III/VI systolic murmurs, those associated with mitral valve prolapse, and apical systolic ejection murmurs that increase with exercise also are indications for referral.[10-12]

Musculoskeletal. The two most useful parts of the musculoskeletal examination are: careful evaluation of old injuries for residual deficits, and thorough examination of the knees and ankles for ligament laxity, whether previously injured or not. The most common previously undiagnosed musculoskeletal findings are patellofemoral syndrome (chondromalacia patella) and scoliosis, although neither is a major disqualifying condition.

Except for significant angulation or shortening of healed long-bone fractures, which are uncommon, the most important injury residuals involve joints, notably knee and ankle, the two most commonly injured joints. Most of the deficits in these joints are from re-injuries, especially recurrent ankle sprains.

Referral to an orthopedic surgeon should be prompt if there is evidence of ankle instability (history of easy inturning, especially on uneven surfaces or sand), or excessive inversion comparing one to the other, painful click, or anterior drawer sign. Do not send the athlete for x-rays without consulting an orthopedist; the orthopedist needs special views.

The physical examination and assessment of an abnormal knee is a complex skill. If an athlete has marked genu recurvatum, knock knees or bowlegs, or patella subluxation, refer the patient for orthopedic evaluation. Also refer any athlete with a history of a physician-treated knee injury, or of giving way or locking, especially those playing football.

Other Systems. The physical examination is not exclusively directed to the cardiovascular and musculoskeletal systems, of course. For example, certain skin conditions, such as herpes, may have relevance to wrestlers. Punctured eardrums should not be missed. Loose teeth and dentures should be noted. A stiff or long, thin neck may be a risk for collision sports. An enlarged spleen requires further investigation. An inguinal hernia, though not necessarily immediately disqualifying, should be repaired before the next season.

Flexibility, Strength, and Performance Testing. Some authorities feel "tight" players are more prone to strains and tendinitis, whereas so-called "loose-jointed" individuals have a higher risk of joint injuries. An isolated loose joint, is more likely from an old injury; the joint may be unstable.

A comprehensive flexibility assessment is described by Nicholas.[13] Also, this five-step flexibility screen is useful: Have the athlete roll head around in all directions, touching ears to shoulders, chin to chest, and back of head nearly touching interscapular area; shrug shoulders against resistance; put both hands behind neck and pull elbows back into the coronal plane of the shoulders; smoothly and quickly bend forward to touch toes (observing rhythm and extent); and bounce up and down several times from the squat position, then "duck walk." Refer to an orthopedist any athlete who fails this test.

Strength and performance tests are so linked to sport specificity that they are best conducted by trainers and coaches of the particular sport. They need not be part of a physician-conducted preparticipation examination.

Maturity Assessment. Competitive team or group assignments based on chronological age or grade level may be suitable for elementary school grades, but because sexual and physical maturation varies widely beginning with junior high school aged athletes, some assessment of physiological maturity may be needed.

The best known assessment is the Tanner staging, based on breast development and pubic hair growth in girls, and pubic hair and genital development in boys.[14] The Tanner score, using a scale of 1 to 5, is useful for boys, and can be determined while examining for hernia. Postmenarche age is preferred for girls. This can be converted to developmental age on a nomogram devised at the Institute of Sports Medicine at Lenox Hill Hospital.

Summary rejection for a given sport of boys who fall below a certain Tanner score, or girls under a certain developmental age is controversial.[15] A program developed by Haffner for the New York state public schools integrates these scores with height and weight, and tests of agility, strength, speed, and endurance; the program probably is a better method for meaningful application of maturity indexes.[16]

Laboratory Testing. Routine laboratory testing is not recommended for preparticipation examinations,[17] although if the sports examination is to be used in lieu of an annual school health physical, many physicians feel compelled to do a complete blood count (CBC) and urinalysis, the latter usually by "dipstick." Although quick and simple, there is a high false-positive rate of proteinuria by this method,[18] usually orthostatic, but which would compel a formal laboratory confirmation on a morning specimen.

For women, a hematocrit may disclose an iron-deficiency anemia, and is recommended for that reason, but a CBC is unnecessary. New Jersey requires no laboratory testing for sports or for school health assessments with the exception of the Mantoux tuberculin test.

RECORDKEEPING

There is a myriad of commercial health history and physical forms, adult and pediatric, and forms furnished by states (New Jersey's are optional), most of which are not appropriate for sports screening.

Schools should use forms to guide the examining physician. The forms can be developed by the school nurse with advice from the school's physician, orthopedic consultant, or by a community-minded physician who has an interest in athletic medicine; such forms facilitate uniform data gathering.

Finally, after the season begins, schools should require injured athletes to have treating physicians send reports to the school's health office for the athlete's record. These can form the basis for annual assessments without the need for another full preparticipation examination.



RECOMMENDATIONS

It is important for the examining doctor—primary care or sports specialist—to specify what sports the student can play, and not just write, "No sports allowed." In fact, the only chronic condition possibly justifying such an unequivocal, across-the-board ban of sports participation is carditis.

The AMA last updated a list of disqualifying conditions in 1976. These recommendations today are rather draconian; with the advent of protective devices and increasing numbers of "right to play" lawsuits challenging rejection of athletes for physical impairments, the Committee on Sports Medicine of the American Academy of Pediatrics (AAP) developed new guidelines in May 1988, that blended medical science with common sense.[20] The AAP study then linked physical conditions with activity classifications (see pages 636 and 637).

If there are any abnormal conditions, the physician should determine classification and limitations, using these guidelines, and make explicit recommendations for participation. If the athlete has decided on a sport beyond his physical ability, the doctor must counsel the athlete, the parents, and the school health or physical education department. Temporary restrictions require a plan of treatment, rehabilitation, and reexamination. If none of the allowable sports are available in school, the young athlete should seek them elsewhere in the community; rarely should sports be prohibited altogether.

If the primary examining physician has referred the athlete for a specialty consultation, the primary physician should incorporate the consultant's findings into one recommendation for the athlete and the school. The school nurse should not have to resolve conflicting recommendations by a primary care physician and a consultant who independently sends a report directly to the school.

CONCLUSION

The best sports preparticipation program requires an initial comprehensive evaluation, interim care, central reporting, and appropriate followup examinations. Tanji regards adolescents as a medically underserved population.[19] The preparticipation ex-

amination, when properly designed and conscientiously carried out, has the potential for meeting the needs of our adolescents, despite a lack of national standards for the much maligned "sports physical." ■

Dr. Ball is a member of the Committee on Publication of *New Jersey Medicine* and an orthopedic surgeon. Requests for reprints may be addressed to Dr. Ball, 1907 Park Avenue, South Plainfield, NJ 07080.

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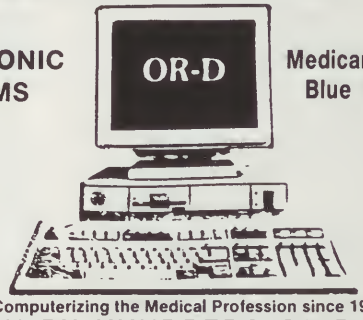
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Children and Sports Medicine in the 1990s

Glenn P. Lambert, MD

Sports participation is an opportunity for children of all ages to improve their fitness, level of maturation, and physical and psychologic condition. A primary physician can play a significant role in promoting enhanced physical fitness in the office or as a team doctor.

Far too few children in the United States participate or engage in adequate physical activity to promote their good health and functional abilities. Many children become "couch potatoes," obese overeaters, or early candidates for cardiovascular disease.[1]

The goal of all practitioners should be to involve every patient in sports or physical activity, whether he is a healthy child or is suffering from a chronic disease, such as asthma, diabetes, congenital heart disease, or a physical handicap. Studies have shown that psychosocial problems occur two to three times more often in children with chronic diseases; yet, sports can provide an opportunity to achieve some independence and reach goals, allow for team participation, and provide an outlet for pent-up energies, aggressiveness, and hostilities.[2] The primary physician should promote sports and exercise for all children as part of a preventive health package.

GOALS OF PARTICIPATION

Many people think of sports as hyped-up events, such as the World Series or the Super Bowl, or as media reports provided by newspapers, magazines, and television. The real goal for children should be fitness. Parents should see that their children walk, run freely, and take the time to limber up, stretch, and relax. School authorities should provide at least three sustained exercise periods a week. Additional sports activities through community organizations should be strongly encouraged.

Children should develop age-appropriate muscle strength and endurance plus flexibility, while avoiding problems of obesity, injuries, and drug use such as anabolic steroids.

The roles of the physician, school, coach, and parents are all intertwined with common goals: activity is fun for children; sports are good activities for physical conditioning; there should be an appropriate degree of competitiveness, appreciating the differences in gender, development, and size; and the importance of participating rather than winning.[3]

RISKS OF SPORTS

Balanced against the positive aspects of sports are the risks: injury, overuse, inappropriate competition/pressure, and stress/burnout. Though these are multifactorial in etiology, factors such as the child's self-esteem, aggressiveness, overall ability, and developmental status may clash with the type of coaching, conditioning, and preparticipation preparation provided for the child athlete.

PARTICIPATION IN SPORTS

It is recommended that physicians and school sports directors follow the "Recommendations for Participation in Competitive Sports Guidelines," written by the American Academy of Pediatrics; the organization has compiled a classification of sports (Figure).[4]

The Table outlines health conditions for participation in sports. It should be noted that a physician's judgment should be the final word in the decision-making process.

PHYSICIAN'S ROLE

It must be emphasized that children should undergo careful preparticipation examinations before engaging in sports and exercise programs. The physician is best trained and experienced to judge whether a child is physically, mentally, and emotionally prepared. Although studies have not shown cost-effective benefits of annual preparticipation sports physicals,[5] school requirements and the current medical/legal climate often indicate that preparticipation physicals be performed. A history and examina-

Table. ***Health conditions for participation in competitive sports (Pediatrics 81:5, 1988).***

	Contact/ Collision	Limited Contact/ Impact	Noncontact		
			Strenuous	Moderately Strenuous	Non-strenuous
Atlantoaxial instability *Swimming: no butterfly, breast stroke, or diving starts	No	No	Yes*	Yes	Yes
Acute illnesses * Needs individual assessment, e.g. contagiousness to others, risk of worsening illness	*	*	*	*	*
Cardiovascular					
Carditis	No	No	No	No	No
Hypertension					
Mild	Yes	Yes	Yes	Yes	Yes
Moderate	*	*	*	*	*
Severe	*	*	*	*	*
Congenital heart disease *Needs individual assessment.[2] † Patients with mild forms can be allowed a full range of physical activities; patients with moderate or severe forms, or who are postoperative, should be evaluated by a cardiologist before athletic participation.[2]	†	†	†	†	†
Eyes					
Absence or loss of function of one eye	*	*	*	*	*
Detached retina * Availability of American Society for Testing and Materials (ASTM)-approved eye guards may allow competitor to participate in most sports, but this must be judged on an individual basis.[3,4] †Consult ophthalmologist	†	†	†	†	†
Inguinal hernia	Yes	Yes	Yes	Yes	Yes
Kidney: Absence of one	No	Yes	Yes	Yes	Yes
Liver: Enlarged	No	No	Yes	Yes	Yes
Musculoskeletal disorders *Needs individual assessment	*	*	*	*	*
Neurologic					
History of serious head or spine trauma, repeated concussions, or craniotomy	*	*	Yes	Yes	Yes
Convulsive disorder					
Well controlled	Yes	Yes	Yes	Yes	Yes
Poorly controlled *Needs individual assessment †No swimming or weight lifting ‡No archery or riflery	No	No	Yes†	Yes	Yes‡
Ovary: Absence of one	Yes	Yes	Yes	Yes	Yes
Respiratory					
Pulmonary insufficiency	*	*	*	*	Yes
Asthma * May be allowed to compete if oxygenation remains satisfactory during a graded stress test	Yes	Yes	Yes	Yes	Yes
Sickle cell trait	Yes	Yes	Yes	Yes	Yes
Skin: Boils, herpes, impetigo, scabies * No gymnastics with mats, martial arts, wrestling, or contact sports until not contagious	*	*	Yes	Yes	Yes
Spleen: Enlarged	No	No	No	Yes	Yes
Testicle: Absence or undescended *Certain sports may require protective cup.[3]	Yes*	Yes*	Yes	Yes	Yes

tion can reveal previous injuries, medical conditions, such as hypertension, and health concerns of the child or adolescent. Physical fitness and condition (strength, flexibility, and stamina) are evaluated; the effects of previous injuries, excessive weight, and cardiovascular problems are noted; the loss of a paired organ detected; and the psychoemotional development can be assessed. Physical maturation using the guidelines of the Tanner Developmental System should be evaluated in adolescence. An example of inappropriate sports participation is that of the late maturing obese boy trying out for the high school football lineman position. He is subject to experience an inordinate number of injuries and also is more likely to suffer heat

Contact/Collision	Limited Contact/Impact	Noncontact		
		Strenuous	Moderately Strenuous	Nonstrenuous
Boxing	Baseball	Aerobic dancing	Badminton	Archery
Field hockey	Basketball	Crew	Curling	Golf
Football	Bicycling	Fencing	Table tennis	Riflery
Ice hockey	Diving	Field		
Lacrosse	Field	Discus		
Martial arts	High jump	Javelin		
Rodeo	Pole vault	Shot put		
Soccer	Gymnastics	Running		
Wrestling	Horseback riding	Swimming		
	Skating	Tennis		
	Ice	Track		
	Roller	Weight lifting		
	Skiing			
	Cross-country			
	Downhill			
	Water			
	Softball			
	Squash, handball			
	Volleyball			

Figure. Classification of sports (*Pediatrics* 81:5, 1988).

stroke in the early months of practice or games. A coach should be the most knowledgeable person recognizing and assessing the child who may be unqualified or lack the skills and stamina for a particular activity despite age, size, or height. Furthermore, the coach must be able to determine and deal with an injury that is life threatening or very dangerous, especially when other adults, trainers, or physicians are not present during practice sessions when most injuries tend to occur.

The injuries that demand immediate medical attention are: significant bleeding; edema of the injured part; loss of complete range of motion of a joint; loss of joint stability; pain and deformity of the injured part, especially when it is moved; tingling or abnormal sensation; the audible tearing, ripping, or popping at the time of injury; altered consciousness/concussion; and shock-like symptoms, especially in hot weather. These are indications that an injury is serious and deserves at least temporary discontinuation of athletic activity. By prompt action, most serious problems can be limited and athletes returned to participation after appropriate care is rendered.

Lastly, the importance of involvement of the physician in sports programs must be emphasized. The presence of a physician at the games and practices provides for on-site assessment and management of injuries, and the application of judgment, that coaches and trainers cannot provide. The practitioner who has the last word on the playing or sitting out of an injured player is the most important person at a competitive event. ■

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Recreational Sports and the Weekend Athlete

Kathryn M. White
Vincent K. McInerney, MD
Paul J. Hirsch, MD

It is important to design an exercise program that provides an adequate amount of activity to attain maximal benefits at the lowest risk to the participant. Permanent lifestyle changes in eating and activity habits should be included in the primary goals of all programs.

Many people are involved in fitness programs. Guidelines for such programs are in great demand. An understanding of an individual's needs and goals, medical history, and present medical and physiological status are necessary in order to recommend an exercise program. Medical, dietary, and fitness evaluations are recommended for individuals entering a health maintenance and exercise program.

Before beginning a program, a preparticipation screening is necessary; this screening measures cardiorespiratory endurance, body composition, muscular strength and endurance, and flexibility (see pages 629 to 633).

AN EXERCISE PROGRAM

The initial exercise program should involve low-to-moderate intensity exercise and slow-to-moderate progression allowing for gradual adaptation to physical activity. It is very important to have a well-rounded exercise program including aerobic activities, muscular strength and endurance activities, and flexibility exercises. No single activity will result in enhancement of total fitness. The four main phases of an exercise program include warm-up, aerobic conditioning, muscle conditioning, and cool-down. The duration of the aerobic and muscle conditioning phases depends upon the individual's health and fitness status, and program goals.

The warm-up period is essential to an exercise program. Proper warm-up may alleviate potential injuries, such as muscle pulls, strains, sprains, and serious cardiac abnormalities. The warm-up period is designed to gradually increase the metabolic rate from a resting level to the level near that of the proposed workout. During the warm-up, the organ systems to be involved in exercise gradually will adapt to the increasing physiological demands of physical activity. The warm-up period lasts five to ten minutes and should involve the major muscle groups to be used in the activity. Walking or jogging, light stretching exercises, and calisthenics are typical exercises performed in the warm-up. Older and less fit individuals generally require a longer warm-up phase.

The cool-down period also is important. Exercises of diminishing intensity are performed for the cool-down. Light activities, such as walking, easy pedaling, or slow jogging, allow the leg muscles to assist the return of blood to the heart. In the absence of recovery period activity, blood will pool in the lower extremities potentially eliciting light-headedness due to inadequate blood flow and oxygen delivery to the heart and brain. Plasma catecholamine levels are greatly elevated during the immediate postexercise recovery period, and increase the risk of cardiac dysrhythmias, ischemia, and hypotension. An active recovery greatly reduces this risk. Cool-down activities should be performed until the heart rate has decreased to less than 100 beats per minute. Cool-down activity also may prevent or lessen the degree of muscle soreness.

Exercise recommendations for an apparently healthy individual should include the optimal frequency, intensity, and duration of training that is necessary for attainment of program goals. Frequency of exercise depends on the duration and intensity of the exercise. Between three to five days per week of training is the recommended frequency range. Individuals with a low fitness level may want to exercise twice each day, 5 to 15 minutes, five days per week. Another training option for a less fit individual is the alternation of a regular exercise session with a session involving lower intensity activity. The point at which an individual can increase the frequency of training sessions depends upon

age, initial fitness level, and intensity of training. For success in weight reduction programs, four to five days per week of training provides better results than three days per week of training.

Training intensity depends on fitness level, health status, and age. The proper intensity level for individuals beginning an exercise program ranges from 50 to 75 percent of maximal heart rate (HRmax) reserve. The appropriate intensity level permits 20 to 30 minutes of continuous aerobic training. Generally, an intensity level of 40 to 55 percent of HRmax reserve is classified as low-intensity training. Moderate intensity ranges from 55 to 75 percent of the HRmax reserve. Periodic fitness evaluations (three- to six-month periods) assess the individual's improvement and enable modification of exercise guidelines to ensure continued progression and participation.

Intensity and duration of training are inversely related. Lower intensity activity should be conducted over a longer period of time. Exercise regimens that expend an equal number of kilocalories will have similar results regardless of whether the results were attained through a long duration, low-intensity regimen (walking) or a high-intensity, short duration regimen (jogging). Sedentary individuals in the first four to six weeks of conditioning are advised to exercise for a moderate duration (20 to 30 minutes) at a moderate intensity level (50 to 65 percent of HRmax). High-intensity exercise is associated with greater risk for injury and lower compliance to training.

Heart rate (HR) is one of the best indicators demonstrating the need for exercise modifications. With conditioning, HR decreases for a given exercise intensity; the exercise prescription should be adjusted to the next level at this time. Health status also must be considered when contemplating the rate of progression. Middle-aged sedentary individuals and older adults generally require more time to adapt to the conditioning stage.

The inclusion of weight training in an exercise program is effective in the development and maintenance of lean body tissue. The adaptive changes observed are specific to the muscles being trained. Each time an alteration is made in the angle or the speed at which the exercise is performed, the exercise functionally changes. The need for standardization of training techniques is imperative, especially when there is a need for transfer of the training effects to a specific sport skill.

For most healthy adults, dynamic variable resistance exercises are recommended. Resistance training should be rhythmical, performed at a moderate-to-slow speed through a full range of motion while maintaining normal breathing patterns. A minimum of 8 to 10 exercises involving the major muscle groups should be performed a minimum of two times per week. At least one set of 8 to 12 exercise repetitions should be completed. The intensity of the training can be varied by changing the weight, repetitions, length of rest between exercises, and number of sets completed. The exercise recommendation should be individualized to meet specific goals and initial ability level. Traditional calisthenic exercises can be effective in improving strength in sedentary, nonathletic individuals, older adults, and special populations.

CONCLUSION

Exercise is a lifetime pursuit, not a periodic attempt to obtain enhanced fitness. A positive attitude toward exercise has to be developed to sustain the interest and enthusiasm necessary for adherence. It is important to design a program that provides an adequate amount of activity to attain maximal benefits at the lowest risk to the participant. Permanent lifestyle changes in eating and physical activity habits should be included in the primary goals of all programs. ■

Drs. Hirsch and McInerney are guest editors of this issue and Dr. Hirsch is past-president of the Medical Society of New Jersey. Drs. Hirsch and McInerney are orthopedic surgeons. Ms. White is an exercise physiologist. Requests for reprints may be addressed to Dr. McInerney, 703 Main Street, Paterson, NJ 07503.

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Sports Injuries in the Female Athlete

Cheryl J. Rubin, MD

An increasing number of women are participating in athletics, both recreationally and competitively. There appears to be greater differences between sports injuries as a result of participation in specific sports rather than due to the sex of the athlete.

Women are participating in competitive and recreational athletics in greater numbers. There are acknowledged anatomic and physiologic differences between male and female athletes, as well as nutritional concerns, and medical problems that are unique to female athletes.

Exercise-related injuries are similar in men and women; greater differences appear between injuries as a result of participation in specific sports activities rather than due to the sex of the athlete. There are, however, certain specific disorders more common in women than in men.

SPORTS INJURIES

Reviews of injury experiences among collegiate women athletes have shown greater dissimilarity in injury patterns between different women's sports than between comparable women's and men's sports.[1] These results indicate that injuries to women athletes are essentially sports-related, not sex-related injuries.[2]

Cox's study of female midshipmen at the United States Naval Academy demonstrated that female midshipmen have the same number of serious injuries as men and, in some sports, are more susceptible to certain types of injuries, such as an increased incidence of anterior cruciate ligament injuries in female basketball players.[3] This study also showed that women sought medical attention for stress-related problems, such as shin splints and stress fractures more often than men, but did so less often as they became acclimated to the active life at the Naval Academy. It remains unclear whether the latter is the result of improved physical conditioning with time, or if the women became accustomed to minor injuries and health problems and learned to ignore them.

It seems that young female athletes and other new athletic participants often have limited presport conditioning that increases susceptibility to overuse injuries. Improved awareness and improvement in training techniques should decrease the incidence of these injuries.[4] The greater varus of the hip and valgus of the knee may contribute to the increased number of overuse syndromes seen about the hip and knee in female athletes.[5]

Several musculoskeletal injuries commonly occur in female athletes: patellofemoral disorders, spondylolysis, stress fractures, shin splints, bunions, and swimmer's shoulder. The issue of breast trauma is specific to women.

Patellofemoral Disorders. A common complaint of female athletes is retropatellar pain. This also is referred to as patellofemoral stress syndrome or, less correctly, by the often associated pathological finding of chondromalacia patellae. This may be found in association with patellar subluxation, patellar dislocation, or maltracking of the patella.

On physical examination, patella alta, genu valgum, genu recurvatum, an increased Q-angle (the angle formed by the intersection of a line drawn from the anterior superior iliac spine to the center of the patella and from the latter point to the tibial tuberosity), and/or a superior insertion point of the vastus medialis obliquus muscle onto the patella often are seen. Pain may result from direct trauma or repetitive activities such as running or swimming.

Therapy is directed at increasing the strength of the quadriceps muscle, especially the vastus medialis obliquus. Hamstring stretching exercises also are helpful in reducing patellofemoral stress. In patients with abnormal patella tracking, centralizing patellar braces may be beneficial during activity. Orthotics may be

indicated in certain patients. Surgical intervention such as arthroscopic shaving and drilling or realignment procedures are indicated in individual patients not responsive to aggressive conservative management.

Spondylolysis. Spondylolysis is a defect in the pars interarticularis of the lumbar spine. In the athletic population, this defect is felt to represent a stress fracture due to repetitive hyperextension of the lumbar spine most commonly seen in female gymnasts. Spondylolisthesis, the forward slippage of one vertebra on the next, is not common in athletes with pars defects, although this defect is seen in the general population with spondylolysis.[5]

The diagnosis of spondylolysis should be considered in athletes with back pain that is not self-limited to several weeks, and especially if it occurs in an athlete participating in an at-risk sport, e.g. gymnastics. Oblique lumbosacral spine radiographs should be obtained with routine AP and lateral views. A bone scan is useful to rule out a stress fracture in this region and is helpful in differentiating an acute injury from an old lesion.

If the x-rays suggest that the lesion is chronic, treatment for the acute symptoms of low back pain should include rest, anti-inflammatory medication, and muscle relaxants. Rehabilitation should include aggressive lumbar flexion, abdominal strengthening, and hamstring flexibility exercises prior to allowing an athlete to return to participation. The treatment of an acute pars defect often is debated. The current recommendation is cast or brace immobilization to permit healing of the "stress fracture" and then reconditioning before allowing return to activity. There is disagreement as to whether or not these lesions will heal, which of these lesions will heal, and how to determine if healing is complete. The degree of protection required when returning to activity also is controversial. There are a few cases where symptoms do not respond to prolonged conservative management with rest, anti-inflammatory medication, and immobilization, and surgical fusion may be indicated.

Stress Fractures. A stress fracture, or fatigue fracture, results from abnormal stress applied to normal bone. Women have a greater incidence of stress fractures than men and an increasing incidence is noted with advancing age. The increased incidence in women may be related to underlying metabolic bone changes and to the relatively smaller bones and articular surfaces in women, as well as the differences in lower extremity architecture. If an athlete is unconditioned, her bones may not have sufficiently hypertrophied to withstand the mechanical stress of exercise.

In the lower extremities, these stress fractures most commonly occur in the proximal tibia, distal fibula, metatarsals, and calcaneus. Patients present with localized pain that is exacerbated by activity and relieved with rest. Plain radiographs may be negative unless symptoms have been present for seven weeks. A bone scan is sensitive in diagnosing early stress fractures and will show a discrete area of increased uptake.

Treatment usually involves rest until symptoms resolve, then strengthening and reconditioning before resuming activity. It may be necessary to correct lower extremity malalignment with orthotics. Rarely is immobilization with a cast or brace necessary and operative stabilization is indicated even less frequently.

Shin Splints. Shin splints are more accurately termed medial tibial stress syndromes—exercise-induced pain along the posterior-medial aspect of the tibia. The pain usually resolves with rest. It may be differentiated from stress fractures on bone scanning by the presence of a diffusely increased uptake along the tibia representing a "periosteitis." On physical examination there is no discrete area of local tenderness demonstrated.

Female athletes may be more prone to this condition due to lower extremity mechanics. Faulty training techniques often are to blame, especially during the early season training in competitive athletics. Symptoms usually resolve with rest and anti-inflammatory medication as well as the use of ice and appropriate reconditioning and modification of training techniques. In certain individuals, orthotics may be necessary for maintenance of alignment during activity. It is important in these patients to differentiate this condition from chronic compartment syndromes.

Bunions. Hallux valgus, with or without metatarsus primus varus, and an associated painful lateral bunion is significantly more common in women than men. This can be problematic for the female athlete, especially those involved in running sports.

Conservative treatment is aimed at shoe modification and appropriate padding to decrease direct pressure over the bunion. Anti-inflammatory agents may be helpful.

If surgical intervention is considered, it is important to avoid altering the biomechanics of the foot, as this may result in subsequent stress fractures, especially in running athletes.

Swimmer's Shoulder. Swimmer's shoulder is a term applied to an overuse syndrome whose presenting symptom is of anterior and anterolateral shoulder pain. The symptoms result from impingement of the coracoacromial arch on the rotator cuff tendon in shoulder abduction and internal rotation. This leads to swelling and inflammation of the tendons and the overlying subacromial bursa. This syndrome is seen in association with the backstroke, crawl, and butterfly.

There is a greater percentage of female swimmers afflicted than male swimmers. The difference may be due to several factors. In order to cover the same distances

as the male with his longer body length, the female must increase the number of strokes and, thus, the number of repeated insults to the shoulder.[5] This syndrome also is seen secondary to anterior shoulder laxity. Since females tend to have greater ligamentous laxity than males, this may contribute to the greater injury incidence in women than men.

On examination, it is important to differentiate primary impingement from impingement secondary to shoulder instability. Treatment usually consists of rest, anti-inflammatory medication, and careful re-evaluation of training techniques. A program of strengthening and flexibility exercise usually is indicated. Surgical intervention may be necessary in patients unresponsive to conservative treatment.

Breast Trauma. With the initial increase in female participation in athletics, especially in potential contact sports, concern regarding breast trauma often was discussed. The incidence of significant injury is very low and rarely is extra breast padding indicated.[6] Another myth is that breasts need maximum support during exercise to prevent irreparable stretching that will cause sagging breasts in later years. The breast is composed of fat tissue and breast tone is lost with aging, apparently unaffected by exercise.[7] The appropriate degree of support for the breasts during exercise should be determined by the individual's preference.

Of note, nipple chafing and excoriation occur in women as well as men, and more often if no brassiere is worn. This is seen most commonly in long-distance runners. One recommendation for decreasing symptoms is the use of Vaseline® smeared on the nipples with or without bandaging.

SUMMARY

Women are successfully participating in a variety of sports in increasing numbers, both recreationally and competitively. There are certain anatomic and physiologic differences between men and women that make each sex unique, but there also are multiple external factors that significantly influence athletic performance. The nature of injuries seems to be more sports-specific than gender-specific. Even the increased susceptibility to overuse syndromes found in women may be reduced by increasing awareness and redefining conditioning and coaching techniques. Further epidemiologic studies of women's athletic injuries will be needed to better define injury patterns and to suggest preventive measures. ■

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The Disabled Athlete: An Approach

Allan M. Levy, MD

Treatment of the disabled athlete should allow the athlete to maximize his remaining abilities and perform at his highest level. The emotional and psychological benefits to the athlete are tremendous, as the athlete will have a greater feeling of self-esteem.

It is extremely important for a disabled athlete to have a sense of belonging to the normal world. It is extremely important for a disabled athlete to feel he can do things nondisabled people do, and that he is not really so different from others. The more a disabled athlete can accomplish, the greater the feeling of belonging, and of self-esteem. I was introduced to this philosophy 30 years ago when I served as a high school team physician.

A student, a post-polio victim, had an atrophied leg; he had been a strong athlete before his illness. Disabled and unable to play, he became morose and disruptive, and his schoolwork suffered. The football coach asked me how we could get this athlete back on the field. With great trepidation, we created a program, limiting his activities to what he could accomplish but making him a member of the team again. He rapidly improved. He played center, where he did not have to run a great deal and began to practice. He learned to protect his weak leg and made such rapid gains that he began to play in scrimmages and in games. There was criticism from parents and fans as he limped onto the field. The second year, the offense was rearranged to take advantage of his talents and avoid his defects. By the time he was a senior, he was the team captain, an all-county selection at his position, and a useful and productive student in school again.

Recently, I saw a young football player barred from playing when an intravenous pyelogram (IVP) revealed he had a single kidney. Football was an important part of his life. His grades fell and he lost interest in school. With our perseverance, an athletic supplier made a vest to protect his remaining kidney. (It had been done at the professional level, so it could be accomplished.) Again, there was a personality change, and the athlete played without injury.

Over the past two years, we have seen a baseball star on the American Olympic Team with only one hand, and a blind hiker who covered the entire extent of the Appalachian Trail with only his guide dog as a companion. These are disabled athletes who made great accomplishments because no one told them they could not do it.

These same principles apply to medically disabled athletes. One need only look at what has happened in the cardiac field: 30 years ago, postinfarct patients were kept in bed for six weeks, continued a prolonged period of inactivity, and returned to a sedentary job. Today, these previously disabled patients are playing competitive tennis and running in 5 K and 10 K races. A similar change in philosophical approach in other disabilities should not be unreasonable.

Among medical conditions most easily amenable to change are respiratory problems. Asthmatics can compete and exercise using oral medications and inhalants. We have several asthmatics in starting roles with the New York Giants, and all, including the most severe, are able to perform easily using medication. A medication program should be overseen by an experienced physician because of the wide variety of drugs, combinations, and side effects. If the athlete is involved in organized competition, he must be aware that some drugs in this category are banned because of their performance-enhancing possibilities. Also, if an athlete is going to use a substance prophylactically for competitive activity he should also use it in practice until he becomes comfortable with the change in performance level that it may bring. However, if the athlete is performing at a recreational level, these considerations should not be a problem.

Exercise-induced bronchospasm (EIB) is another disabling respiratory problem. These athletes experience coughing and wheezing due to excessive amounts of cold, dry air that is not sufficiently warmed and moisturized before entering the bronchial tree as the respiratory rate increases. Simply moving activity indoors in cold weather and running on a treadmill instead of on the road will solve the problem. In those persons with more severe symptoms, a change in activity will solve the problem. The warm, damp air of an indoor swimming pool almost always will prevent onset of symptoms. Many athletes with EIB run in the summer and swim in the winter.

It has been widely felt that epileptics should avoid contact sports because of the possibility of head trauma. And yet, there are epileptics playing in professional contact sports without difficulty. A properly medicated epileptic can engage in any type of sports activity. Many neurologically disabled people can exercise and perform well. There is even a postencephalitis patient with hydrocephalic problems and a peritoneal shunt kicking in the National Football League.

For the diabetic patient, an exercise program is not only possible, but actually is beneficial. Programmed exercise reduces the insulin requirement in most diabetics and helps to decrease the brittleness of the juvenile diabetic.

The largest group of disabled athletes are the elderly. So often, the aged no longer are able to exercise due to disability from pain, weakness, or lack of stamina and no one approaches this group with substitute activities. Yet, the elderly jogger who no longer can run, can walk. He can ride a stationary bike or swim; both of these activities are nonweight bearing. Many elderly people do extremely well with water calisthenics and aerobics that lessen joint trauma. Physicians must realize what is happening to our older patients and provide them with the ability to remain active.

There are groups of the disabled whose problems preclude certain activities, not on the basis of inability to perform, but because further risk of disability is involved. Spine trauma is an example. The athlete with symptomatic spondylolisthesis must be out of heavy contact sports, or those sports that require explosive extension, such as gymnastics and diving. Cervical stenosis would rule out football and soccer where head and neck trauma is common. The possibility of cord trauma far outweighs any benefit from participation in this type of sport. Those people with low back weakness or discogenic disease do not belong in sports where heavy lifting is involved. Also included in the group are the athletes with sequellae from brain trauma. These people must be guided into activities where chance of further trauma is eliminated or at least totally minimized.

CONCLUSION

This article attempts to provide physicans with a way of looking at the disabled athlete. It is necessary for physicians to help patients succeed.

We must consider the patient's desires and decide whether they are realistic. If they are realistic, we can help find the means to accomplish these goals. This may include training programs, expert assistance, prosthesis, or medications. The athlete should be encouraged and supported. If the goals are not realistic, he should be guided in another direction rather than discouraged. And remember what we consider unrealistic at first glance may be wholly achievable if we research alternate pathways.

The decision to put a disabled patient on the football field took real soul-searching. But 30 years later, I still feel that it was a decision that changed a life for the better. ■

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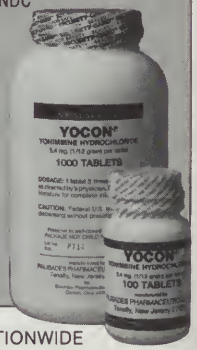
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Sports Medicine for the Diabetic Athlete

Antonio Morgado, MD
Stephen H. Schneider, MD

Exercise can be a useful therapy for patients with type II diabetes mellitus. Improvements in body composition, glucose tolerance, insulin sensitivity, cardiovascular profile, and psychological state are some benefits. The benefits of exercise will enrich the lives of diabetics.

Diabetes mellitus affects approximately 14 million individuals in the United States, 90 percent of whom have type II or noninsulin dependent diabetes mellitus. Type I diabetes mellitus is characterized by absolute insulin deficiency resulting from immunologic destruction of the pancreatic islets; type II diabetes mellitus insulin resistance is the most characteristic finding, especially early in the disease.[1]

Exercise often is recommended as an adjunct to pharmacologic and dietary treatment of diabetes mellitus.[2] In addition to metabolic benefits, exercise may serve to reduce cardiovascular risk factors that contribute to the premature morbidity and mortality of diabetics. Exercise also can provide the diabetic patient with a sense of well being and improved quality of life.

METABOLIC CHANGES

The metabolic response to exercise varies with several factors including the intensity and duration of exercise, nutritional status, and the state of training.

Patients with type I diabetes mellitus under good metabolic control have been shown to have a normal exercise capacity. However, patients with poor glycemic control may demonstrate impaired endurance secondary to dehydration, glycogen depletion,[3] and abnormal substrate metabolism with a premature switch from carbohydrate to fat and ketone utilization.[4] Noninsulin dependent diabetics often have an abnormally low VO_2 maximum that is independent of glycemic control.[5] This may reflect subtle lifestyle differences, or a primary genetic defect. Other factors such as an abnormal body composition may play a role.

GLYCEMIC CONTROL

Exercise in diabetic patients leads to a reduction in blood glucose as a result of enhanced muscle uptake of glucose. Increased insulin sensitivity as well as an increase in the functional cross-sectional area of blood vessels in muscle may account for this phenomenon.

Hypoglycemia may occur especially in insulin-treated patients since the absence of the physiological fall in insulin levels as a result of the presence of depot subcutaneous insulin leads to a relative hyperinsulinemia that limits hepatic glucose output and lipolysis. In addition, activation of the counter-regulatory hormones, particularly epinephrine and glucagon, may be deficient in some patients with type I diabetes.[6] The risk of hypoglycemia during exercise may be exaggerated by activity of muscle underlying the injection site that leads to its more rapid absorption.[7] This effect is more important when exercise is performed within one hour of the injection and when short-acting insulin is used. Exercising in warm temperatures also may enhance insulin absorption. Hypoglycemia is more likely to occur with exercise later in the day when the hypoglycemic effects of exercise have been shown to be greater.

Although hypoglycemia related to exercise most commonly occurs 30 to 40 minutes after the onset of activity, hypoglycemia also may develop six to ten hours after exercise.[8] The mechanism of this phenomenon of "delayed" hypoglycemia has not been explained, but it can be quite severe.

Paradoxically, hyperglycemia may occur during exercise in some patients when glucose output exceeds peripheral glucose disposal. This can occur very transiently in any individual following a brief episode of extremely intense activity. However, it can occur with more modest aerobic exercise in patients with severe insulin deficiency, usually reflected by a fasting blood glucose in the range of 300 mg/dl, and often associated with ketonuria.[9,10]

The beneficial effects of regular exercise and training on glycemic control is more obvious for patients with noninsulin dependent diabetes mellitus.[11] This is to be expected since exercise reverses the insulin insensitivity that is an important defect of type II diabetes. Following exercise, a period of increased insulin sensitivity lasting as long as 72 hours has been observed.[12] Several explanations for this effect have been offered including up-regulation of insulin receptors, the formation of "muscle activity factors" with insulin-like actions,[13] and altered postinsulin receptor mechanisms. The latter hypothesis is supported by the recent findings of increased numbers of glucose transporters following exercise.[14] The glucose transporters normally mediate insulin action by transporting glucose from the cell surface to the intracellular space. Quantitative and/or qualitative defects in glucose transporters may play a major role in the insulin resistance of type II diabetes. Similarly, triglyceride levels also are reduced for up to 72 hours following aerobic exercise.[15]

The metabolic effects of exercise have little relationship to training or the trained state per se. Glucose tolerance, enhanced by physical training, can return to baseline even after months of physical training within 48 to 72 hours after the last exercise session. Therefore, the improvement in glycemic control probably is related to the effect of individual exercise sessions performed on a regular basis.[16]

While insulin sensitivity can be shown to improve independently of alterations in body composition, increased muscle mass also may facilitate glucose disposal.[17]

The patients most likely to improve their glycemic control with regular exercise are the type II diabetics with hyperinsulinemia and mild hyperglycemia (fasting blood and sugar less than 220 mg/dl). In patients with insulin dependent diabetes, it has been difficult to demonstrate any overall benefit in glucose control, on a program of regular physical training.[18] Although insulin sensitivity does increase, improved glycemic control may be negated by more frequent snacking and by reductions in insulin dosage in an effort to prevent exercise-related hypoglycemia. A select population of type I diabetics under good metabolic control and willing to be monitored intensively, however, may benefit from an exercise program.[19]

Table 1. ***Potential complications of exercise in patients with diabetes.***

General

1. Cardiac ischemia related to occult coronary artery disease
2. Exaggerated blood pressure response to exercise
3. Postural hypotension
4. Heat and cold intolerance
5. Foot injury
6. Degenerative arthritis
7. Poor dietary compliance
8. Expense

Metabolic

1. Hyperglycemia and ketosis
2. Hypoglycemia
3. Hyperkalemia (?)

Microvascular

1. Retinal bleeding
2. Proteinuria
3. Worsening microvascular disease

CARDIOVASCULAR RISKS

Although the pathogenesis of atherosclerosis in diabetic patients has not been determined, multiple factors that commonly occur in diabetes are likely to be important, including hypertension, elevated triglycerides, decreased HDL cholesterol, hyperinsulinemia,[20] and impaired fibrinolytic activity. A lower threshold for ventricular fibrillation also has been demonstrated in diabetic patients.[21] Regular exercise has been shown to ameliorate these risk factors, although there are no prospective studies specifically demonstrating a reduction in cardiovascular mortality in diabetics due to physical training.[22]

Recently, particular attention has been drawn to the role of hyperinsulinemia. Epidemiologic studies and animal research have provided some evidence for the causal role of hyperinsulinemia in hypertension, impaired fibrinolytic activity, and atherosclerosis.[23] The ability of exercise to allow improved glycemic control while decreasing ambient insulin levels makes it an attractive candidate for attacking this particular problem.

COMPLICATIONS

Exercise in patients with diabetes mellitus can be associated with potential complications (Table 1).

General complications. Accelerated atherosclerosis and coronary artery disease are highly prevalent in the diabetic population. Also, many of these patients have silent ischemia compared to the general population. Exercise stress testing should be part of the initial evaluation of the diabetic contemplating a training program.[24]

Peripheral neuropathy and vascular disease impart a significant risk of foot and joint injury. This is mostly secondary to loss of sensation involving pain and proprioception and muscle atrophy. Frequent inspection of the feet and joints is essential as well as the use of proper footwear. Those patients with severe neuropathy or peripheral vascular disease should avoid activities that may lead to foot and joint trauma. An alternate exercise such as swimming is preferred.

Microvascular complications. Patients with proliferative retinopathy are at risk of retinal hemorrhage when engaging in exercise capable of producing wide fluctuations in blood pressure, i.e. those involving excessive straining and Valsalva-type maneuvers.

In addition, retinal hemorrhages may result from hypoglycemia, direct trauma to the eyes, or from shear forces caused by rapid eye movement.

Renal function has not been shown to be adversely affected by exercise. However, concern has been raised about the effects of transient hypertension seen in some patients during exercise. It should be noted that many patients with diabetes and normal resting blood pressures have an exaggerated blood pressure response to exercise. These patients can be identified in pretraining exercise and their exercise recommendations can be modified accordingly.[25]

Proteinuria often is detected following exercise in diabetic patients and is related to the level of blood pressure elevation during exertion;[26] it is unknown if this has any consequences.

Metabolic complications. Most diabetic patients using insulin who exercise regularly experience hypoglycemia. This is a problem primarily in patients taking significant amounts of exogenous insulin, but it can be seen in patients on oral agents. It is a rare problem for patients treated with diet alone.

Patients should be encouraged to exercise early in the day in order to prevent delayed hypoglycemia from occurring at night when the patient is sleeping. Also, the hypoglycemic effect of exercise is generally of less magnitude in the morning.[27]

Supplemental carbohydrate is a practical way of avoiding hypoglycemia. Fifteen to 30 g of readily absorbable carbohydrate every 30 minutes of aerobic exercise usually is sufficient. Postexercise snacks may be helpful. In those patients requiring insulin, dose reduction and frequent self-monitoring of glucose are keys to prevention of hypoglycemia. Patients on oral hypoglycemic agents also may require a reduction of the dosage. Other drugs that may predispose to, or mask the symptoms of hypoglycemia, such as beta blockers, should be avoided. Finally, patients with diabetes mellitus always should carry a source of carbohydrates such as glucose tablets and use them at the very first symptom of hypoglycemia. Identification such as a Medic Alert™ bracelet should be worn.

EXERCISE PROGRAM

A pre-exercise evaluation (Table 2) should be performed on all patients contemplating a regular training program. Particular emphasis should be placed on identifying chronic complications of diabetes such as microvascular, macrovascular, and neurological disease. An exercise stress test has been recommended for all patients older than 35 years, and patients at any age with diabetes of more than 10 years' duration in order to uncover silent ischemia and establish the blood pressure response to exercise.[2] In those patients with significant coronary artery disease, vascular disease or severe neuropathy, complications of intensive exercise may outweigh the benefits. Subjects with absolute insulin deficiency and fasting hyperglycemia (over 250 mg/dl) should avoid exercise in view of the possibility of paradoxical hyperglycemia and ketosis.

Table 2. ***Exercise prescription.***

Type

1. Aerobic
   - — Cardiovascular fitness
   - — Lipids
   - — Low injury and complication rate
2. Anaerobic
   - — High complication rate

Intensity

1. Stretch
2. Warm-up
3. >50% maximum and BP < 180-200 mm Hg systolic
4. Cool-down (10 min at 20 to 30% of exercise level)

Duration

1. >15 minutes; <1 hour
2. 90 second rest periods

Frequency

1. At least:
   - — 3 times week/glycemic control
   - — 5 times week/weight reduction
2. Do not substitute intensity for frequency

Some type I diabetics also can benefit from regular recreational exercise. Personal preference and the patient's medical condition determine the type of exercise. A period of 5 to 10 minutes should be devoted to stretching and low activity exercise prior to each exercise bout. Exercise at 50 to 75 percent of VO_2 maximum lasting 20 to 45 minutes is recommended for maximum cardiovascular gain. Lower intensity is desirable if systemic blood pressure exceeds 180 mm Hg. This is best determined during the pretraining stress tests. Patients with noninsulin dependent diabetes often have a reduced exercise capacity and may require a lower intensity of exercise at the onset of the training program. Ninety second breaks during the exercise periods have been shown not to negate the metabolic benefits. Less intense activity such as walking also may impart cardiovascular and metabolic benefits if performed for prolonged duration, but rarely result in significant improvements in insulin sensitivity. It is recommended that exercise be performed at least three times a week. Higher frequency is necessary if weight reduction is desired.

A gradual discontinuation of activity and ten-minute period of lower intensity of exercise preferably at a heart rate of 10 to 15 beats per minute above resting values is recommended in order to reduce postexercise blood pressure fluctuations and cardiac dysrhythmias as well as musculoskeletal problems.

CONCLUSION

Regular exercise can be a useful adjunctive therapy for most

patients with type II diabetes mellitus. Improvements in body composition, glucose tolerance, insulin sensitivity, cardiovascular risk factor profile, and psychological state are likely benefits. For the patient with type I diabetes, complications are more common and benefits are less well defined. Some disciplined patients may find exercise to be a useful therapeutic tool for improving glucose control but for most type I patients, the physician should allow recreational and work-related activities, with a minimum of restrictions. The joys and benefits of physical activity can be safely made available to most patients with diabetes to enrich and enhance their quality of life. ■

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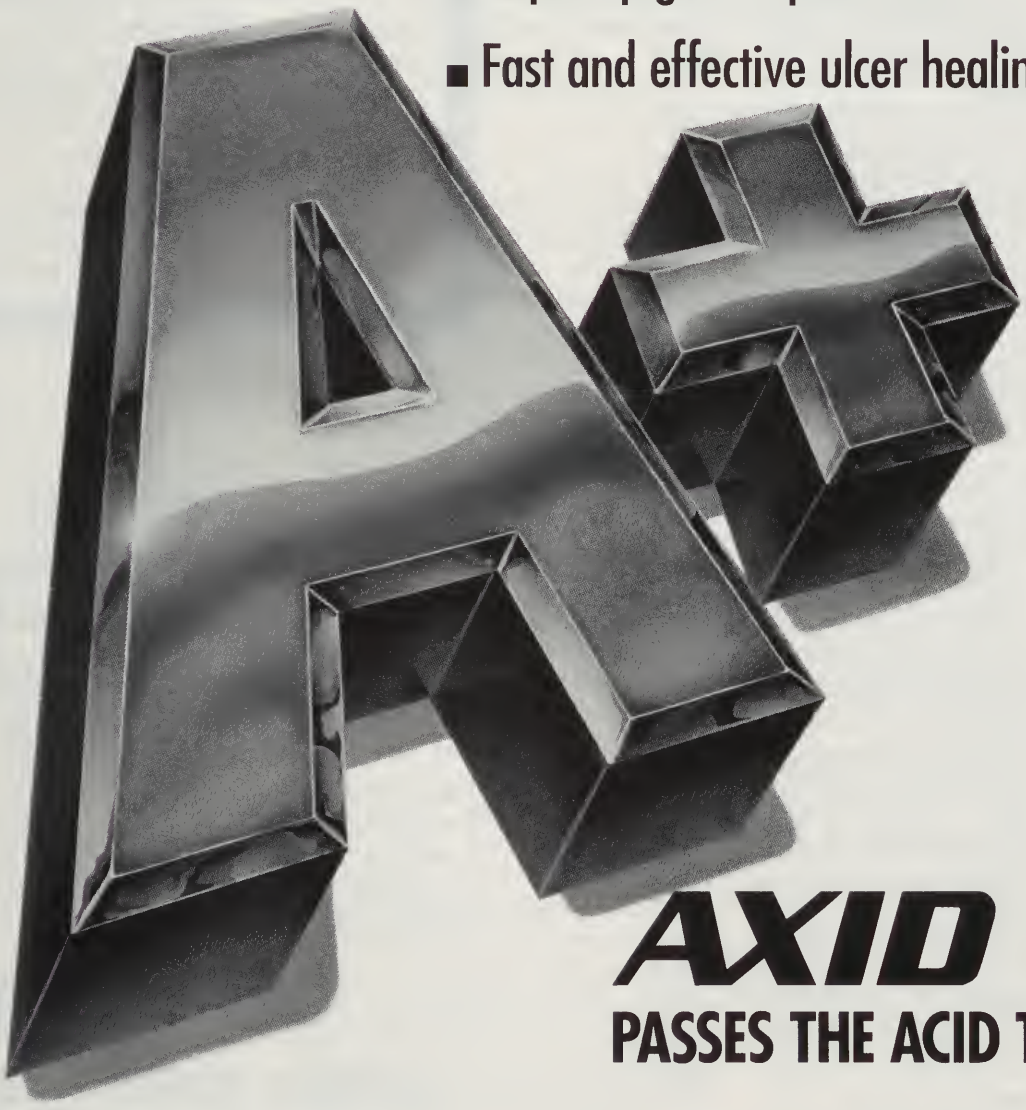
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Carcinogenesis, Mutagenesis, Impairment of Fertility – A 2-year oral carcinogenicity study in rats with doses as high as 500 mg/kg/day (about 80 times the recommended daily therapeutic dose) showed no evidence of a carcinogenic effect. There was a dose-related increase in the density of enterochromaffin-like (ECL) cells in the gastric oxyntic mucosa. In a 2-year study in mice, there was no evidence of a carcinogenic effect in male mice, although hyperplastic nodules of the liver were increased in the high-dose males as compared with placebo. Female mice given the high dose of Axid (2,000 mg/kg/day, about 330 times the human dose) showed marginally statistically significant increases in hepatic carcinoma and hepatic nodular hyperplasia with no numerical increase seen in any of the other dose groups. The rate of hepatic carcinoma in the high-dose animals was within the historical control limits seen for the strain of mice used. The female mice were given a dose larger than the maximum tolerated dose, as indicated by excessive (30%) weight decrement as compared with concurrent controls and evidence of mild liver injury (transaminase elevations). The occurrence of a marginal finding at high dose only in animals given an excessive and somewhat hepatotoxic dose, with no evidence of a carcinogenic effect in rats, male mice, and female mice (given up to 360 mg/kg/day, about 60 times the human dose), and a negative mutagenicity battery are not considered evidence of a carcinogenic potential for Axid.

Axid was not mutagenic in a battery of tests performed to evaluate its potential genetic toxicity, including bacterial mutation tests, unscheduled DNA synthesis, sister chromatid exchange, mouse lymphoma assay, chromosome aberration tests, and a micronucleus test.

In a 2-generation, perinatal and postnatal fertility study in rats, doses of nizatidine up to 650 mg/kg/day produced no adverse effects on the reproductive performance of parental animals or their progeny.

Pregnancy – Teratogenic Effects – Pregnancy Category C – Oral reproduction studies in rats at doses up to 300 times the human dose and in Dutch Belted rabbits at doses up to 55 times the human dose revealed no evidence of impaired fertility or teratogenic effect; but, at a dose equivalent to 300 times the human dose, treated rabbits had abortions, decreased number of live fetuses, and depressed fetal weights. On intravenous administration to pregnant New Zealand White rabbits, nizatidine at 20 mg/kg produced cardiac enlargement, coarctation of the aortic arch, and cutaneous edema in 1 fetus, and at 50 mg/kg, it produced ventricular anomaly, distended abdomen, spina bifida, hydrocephaly, and enlarged heart in 1 fetus. There are, however, no adequate and well-controlled studies in pregnant women. It is also not known whether nizatidine can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Nizatidine should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers – Studies in lactating women have shown that 0.1% of an oral dose is secreted in human milk in proportion to plasma concentrations. Because of growth depression in pups reared by treated lactating rats, a decision should be made whether to discontinue nursing or the drug, taking into account the importance of the drug to the mother.

Pediatric Use – Safety and effectiveness in children have not been established.

Use in Elderly Patients – Healing rates in elderly patients were similar to those in younger age groups as were the rates of adverse events and laboratory test abnormalities. Age alone may not be an important factor in the disposition of nizatidine. Elderly patients may have reduced renal function.

Adverse Reactions: Clinical trials of varying durations included almost 5,000 patients. Among the more common adverse events in domestic placebo-controlled trials of over 1,900 nizatidine patients and over 1,300 on placebo, sweating (1% vs 0.2%), urticaria (0.5% vs <0.01%), and somnolence (2.4% vs 1.3%) were significantly more common with nizatidine. It was not possible to determine whether a variety of less common events were due to the drug.

Hepatic – Hepatocellular injury (elevated liver enzyme tests or alkaline phosphatase) possibly or probably related to nizatidine occurred in some patients. In some cases, there was marked elevation (>500 IU/L) in SGOT or SGPT and, in a single instance, SGPT was >2,000 IU/L. The incidence of elevated liver enzymes overall and elevations of up to 3 times the upper limit of normal, however, did not significantly differ from that in placebo patients. All abnormalities were reversible after discontinuation of Axid. Since market introduction, hepatitis and jaundice have been reported. Rare cases of cholestatic or mixed hepatocellular and cholestatic injury with jaundice have been reported with reversal of the abnormalities after discontinuation of Axid.

Cardiovascular – In clinical pharmacology studies, short episodes of asymptomatic ventricular tachycardia occurred in 2 individuals administered Axid and in 3 untreated subjects.

CNS – Rare cases of reversible mental confusion have been reported.

Endocrine – Clinical pharmacology studies and controlled clinical trials showed no evidence of antiandrogenic activity due to nizatidine. Impotence and decreased libido were reported with equal frequency by patients on nizatidine and those on placebo. Gynecomastia has been reported rarely.

Hematologic – Fatal thrombocytopenia was reported in a patient treated with nizatidine and another H_2-receptor antagonist. This patient had previously experienced thrombocytopenia while taking other drugs. Rare cases of thrombocytopenic purpura have been reported.

Integumental – Sweating and urticaria were reported significantly more frequently in nizatidine- than in placebo-treated patients. Rash and exfoliative dermatitis were also reported.

Hypersensitivity – As with other H_2-receptor antagonists, rare cases of anaphylaxis following nizatidine administration have been reported. Rare episodes of hypersensitivity reactions (eg, bronchospasm, laryngeal edema, rash, and eosinophilia) have been reported.

Other – Hyperuricemia unassociated with gout or nephrolithiasis was reported. Eosinophilia, fever, and nausea related to nizatidine have been reported.

Overdosage: Overdoses of Axid have been reported rarely. If overdosage occurs, activated charcoal, emesis, or lavage should be considered along with clinical monitoring and supportive therapy. Renal dialysis does not substantially increase clearance of nizatidine due to its large volume of distribution.

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Exercise and Arthritis in the 1990s

Carl Restivo, Jr, MD

Arthritis sufferers want to share in the benefits of exercise without increasing their pain. Too much physical activity can increase the inflammatory response in arthritic joints. Walking is the ideal form of exercise, as it is fun, simple to do, and beneficial.

Arthritis affects 35 million Americans. Over 1 million of these victims live in New Jersey. The majority are productive people hampered to some degree by their condition: they suffer with stiffness, aches, pains, and moderate functional limitations. Those with arthritis want the benefits of exercise without increasing their pain. Furthermore, they fear further damage to their joints caused by the activity intended to be beneficial.

What are the benefits of exercise? In addition to an increase in endurance and cardiovascular conditioning, exercise reduces the risks of osteoporosis. Calcium, vitamin D, and sodium fluoride are of little benefit in a sedentary patient. Physical activity increases the levels of endorphins (endogenous morphine-like substances) in the brain that combat the effects of stress and pain. Depression, often accompanying any chronic illness, can be reduced by physical exertion. In a broad sense, exercise also increases the arthritis patient's sense of accomplishment and well being.

Too much physical activity can increase the inflammatory response in arthritic joints and increase the patient's pain and decrease overall functional capacity. The risk of overly strenuous physical activity is injury to the body. Many types of exercise that are beneficial to healthy people are simply not well suited to those with arthritis. These depend on the joints involved. For example, repetitive movement, such as bicycling for too long with an osteoarthritic knee, can deteriorate joint architecture. Too vigorous physical activity can damage bones, tendons, ligaments, and muscles. The ideal form of exercise for these patients should be fun, simple to do, safe, and aerobic, and spare the participant undue risk of significant injury.

Walking is one example of exercise; under the right conditions, walking at a brisk pace can be gentle, natural, and beneficial. The ideal minimum walking pace can be as low as 40 percent of maximum oxygen consumption; this is approximately 40 percent of maximum predicted heart rate.[1,2] In numerous studies, walking has been shown to reduce the incidence of coronary artery disease, hypertension, osteoporosis, and obesity.[3-5] Walking, even at a slow pace, can condition and train the body if that person has been performing minimal physical activity. Running, on the other hand, is too stressful to the joints and muscles to benefit the person with arthritis.

The Arthritis Foundation, New Jersey Chapter, has exercise programs in most counties, including low-impact aerobic exercises designed primarily for the person with arthritis. In addition, the Foundation has water exercise programs in pools heated to 82°F; these programs are led by physical therapists throughout the state.

The principles of exercise for people with arthritis are similar but not identical to those of people without arthritis. In both groups, the warm-up period is of critical importance. Stretching the tendons and ligaments prior to intense activity decreases the chance of tears and sprains. In the arthritic patient, this period should last a little longer. Cartilage increases its water content during the early stages of physical activity; to some degree, this protects the joints from injury.

The use of nonsteroidal anti-inflammatory drugs (NSAIDs) in exercise programs is controversial. Patients who do not routinely take NSAIDs often will benefit from pretreatment with these drugs prior to their exercise. As the exercise program continues, NSAIDs no longer are required for analgesia and anti-inflammatory benefit.

Arthritics, even more than other persons, should begin any physical activity program at a minimal level, and gradually increase time and intensity. Twenty minutes or less is a good initial walking program. Attempts to increase a program too rapidly lead to risk of serious injury. Tolerance and endurance should be developed slowly and steadily to reduce risks.

If brisk walking causes chest pains or cramps, the activity should be discontinued. "Listen to your body" is a phrase patients often recall after a visit to a physician. The arthritis sufferer is likely to discover that the previous day's exertion is followed by increased stiffness and pain.

Elastic support for damaged joints can protect them by limiting their range of motion and keeping the damaged joints warmer than they would be without elastic support.

Just as important as the warm-up period, is the cool-down period. For several minutes, one should gradually reduce the physical activity level and repeat previous stretching maneuvers. If a joint becomes symptomatic after exercise, 10 to 20 minutes of icing can reduce the inflammatory response.

CONCLUSIONS

Exercise is therapeutic. The majority of those suffering with rheumatic disorders can reap the benefits of exercise including a fuller, healthier, less stress-ridden, and more productive life. ■

Dr. Restivo is president of the Arthritis Foundation, New Jersey Chapter, and a member of the MSNJ Board of Trustees. Requests for reprints may be addressed to Dr. Restivo, 3 Webster Avenue, Jersey City, NJ 07307.

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Update on Sports Nutrition

Richard Levandowski, MD
Beth Young, MS, RD

Adequate nutrition is vital to peak athletic performance. Insufficient energy and fluids can hinder ability to compete. Physicians and dietitians must emphasize nutrition's importance to athletes. Sports nutrition follows the same principles as good nutrition.

Nutrition is a cornerstone of athletic performance. If an athlete has insufficient fuel stores (nutrients) or intake to function at peak performance level, he may not be able to attain athletic potential. Too often individuals spend considerable time and energy striving for the optimum in exercise performance only to fall short due to inadequate, counterproductive, and sometimes harmful nutritional practices.[4] Deficient consumption of nutrients, electrolytes, and water can hinder athletic performance.

This article is written to help physicians educate patients attain optimal nutritional health so athletes can achieve peak performance.

GOAL SETTING

Energy and nutritional requirements vary, depending on weight, height, age, sex, metabolic rate, type of exercise, intensity of training, and the duration of the sport.

Weight Goal. The first step in computing an appropriate weight goal is to determine body fat. Essential body fat for males is 3 percent and for females is 12 percent. A low-fat diet and exercise program should be followed until percent body fat reaches ideal level. When ideal body fat level is attained, weight will be at its proper level and may be higher than normal weight charts.

Nutritional Goals. Suggested nutritional goals for optimal performance and strength include:

- Maintain weight within a five-pound weight range.
- Minimum caloric intake should not fall below 1,500 calories/day for males or 1,200 calories/day for females.
- Optimal muscle growth can be achieved with a 1.5 to 1.8 g/kg body weight protein intake.
- Less than 25 percent of calories from fat and 60 percent of calories from carbohydrates are necessary.
- Twenty-five to 30 g of fiber per day will ensure complex carbohydrates are being eaten.
- At least two quarts of water daily are needed.
- Less than 300 mg/day of cholesterol and less than 200 mg/day of caffeine are proper.
- If there is not much sweating, 1,100 to 3,300 mg/day of sodium is required.

Physicians should stress that athletes eat at least three meals a day. Long periods without eating will slow the body's metabolic rate. Lowering the metabolic rate is contradictory to weight loss. During periods of weight loss, metabolic rate should be at its highest to make weight loss as easy as possible. During long periods of fasting, blood sugar levels may decrease in some individuals causing fatigue, crankiness, and dizziness.

Caloric Goals. A quick way to calculate caloric requirements is to multiply goal weight in pounds by an activity factor (between 10 and 17 depending on activity level). For an extremely active athlete with a high metabolism, use a factor of 17; most young athletes in training will use a factor of 15. To lose a pound of body weight, there must be a calorie deficit of 3,500 calories. By subtracting 500 calories per day, a one-pound weight loss per week would occur.

Carbohydrate, Fat, and Protein Goals. The recommended carbohydrate intake is at least 60 percent of total calories. Individuals must have 200 calories/day or 50 g of carbohydrates for normal brain function. There are 4 calories/g of carbohydrate.

The recommended fat intake is less than 30 percent of calories. However, it is suggested that athletes take in less than 25 percent of calories from fat. Fat has 9 calories/g.

The recommended protein intake for males and females is 15 percent of total calories. Protein has 4 calories/g.

CALCULATING MEALS

Calculating an individualized meal plan can be done by using *The Exchange Lists for Weight Management.*[1] This manual will simplify diet planning, minimize calorie counting, and increase variety by expanding food knowledge. There are six exchange lists: starch/bread, meat, vegetable, fruit, milk, and fat.

MACRONUTRIENTS

Fluids. Sixty percent or more of the human body's weight is water. Proper fluid balance is essential for peak athletic performance. A 1 to 2 percent loss in body weight from dehydration can affect performance by causing fatigue. Blood volume decreases relatively rapidly during dehydration.



The keys to proper hydration are: to drink at least two quarts of water daily (cool water, not ice cold water, is absorbed most quickly); to realize proper fluid balance is important in weight control since it helps the body metabolize fat and eliminate metabolic waste products; and to drink two cups of water for each pound lost during exercise.

Fluid and electrolyte replacement beverages, so-called sports drinks, may be an easy way to replenish sodium, potassium, chloride, and carbohydrates after a strenuous workout. In dehydration, a sodium/potassium solution may increase blood volume more rapidly than plain water.[5] Fluid replacement beverages are not necessary during a light workout where dehydration is not a problem. If heat regulation, not blood volume, is the main goal, water is best to drink.

For rapid fluid and nutrient replacement, glucose and sodium in dilute concentrations are potent stimuli for fluid absorption in the small intestine. A glucose concentration of 6 to 8 percent apparently is optimal for intestinal absorption.[5] Very dilute glucose/sodium solutions, when consumed before and during an event, also show an improved exercise endurance. Glucose/sodium solutions are best for intense training when glycogen replenishment is necessary and sweat production is high. During light training where glycogen use is low, these solutions may cause excess caloric consumption and contribute to weight gain.

Protein. The average person requires about 0.8 g of protein per kg (0.36 g/lb) of body weight. There appears to be some benefit to increasing protein requirements to 1.3 to 1.8 g/kg per day for those who are in strength training. However, there is an upper limit to the positive effect of protein on strength. Excessive protein may hurt performance by: leaching calcium from the bones; converting to body fat; causing increased stress on kidneys to breakdown protein; and causing further dehydration since fluid is lost when metabolizing protein.

Carbohydrates. Carbohydrates are the primary fuel for muscle contraction. Carbohydrates are stored in the liver and muscle as glycogen. Energy from muscle is released up to three times faster than energy from fat. When glycogen is depleted from muscle, exercise intensity and duration decrease and fatigue occurs. After a hard workout, it takes about 20 hours to replenish muscle glycogen.

Endurance athletes, those who compete in continuous activities that last at least an hour, should replenish glucose and fluids during the event. These athletes should drink a half cup of cool water or a dilute glucose/electrolyte replacement beverage every 15 minutes. Endurance athletes should consume a high-carbohydrate diet prior to the event. Glycogen stores must be at their highest level at the beginning of the competition. Fat intake also must be relatively low just prior to the event to help prevent nausea and cramping.

Sixty percent or more of daily caloric intake should be complex carbohydrates and less than 10 percent simple sugars (honey, jams, sugar, jellies, syrup, molasses, and apple butter). Complex carbohydrates (starches) are potatoes, buckwheat, rice, oats, pasta, chickpeas, bread, peas, kidney beans, and corn.

Fiber is the part of foods the human body is unable to digest. Many national health organizations are recommending 25 to 30 g/day as the optimal intake. The average American now consumes only 10 to 15 g of fiber per day. The health benefits of adequate fiber may include a decrease in the risk of colon cancer; decreased incidence of hemorrhoids; feeling of fullness or satiety when on a low-fat diet; and ease of waste elimination.

Dietary Fat and Cholesterol. Decreasing dietary fat probably is the single most important factor in losing and maintaining weight.

Current recommendations are to eat a balance of all three types

of fats: saturated, monounsaturated, and polyunsaturated. The goal should be equal amounts of total fat from each of the three groups.

It is important to concentrate on decreasing total fat intake during weight loss since dietary fat, apparently, turns to body fat more efficiently than carbohydrates and protein. Dietary fat can drop to 10 percent of calories without a detrimental effect.

PRE-EVENT MEAL

The pre-event meal psychologically is important. If possible, eating three hours prior to an event should give adequate absorption time. The meal should be low in fat; fat is absorbed slowly from the stomach. The pre-event meal also should be high in carbohydrates and moderate in protein. High protein intake is not advised since protein takes two to three hours to digest. High protein foods also are usually high in fat. Carbohydrates take about 30 to 90 minutes to digest, and are absorbed most quickly from the intestine. Complex carbohydrates do not cause as great an increase in blood sugar, as simple sugars. Candy is mostly simple sugar. Simple sugar causes a temporary elevation of blood glucose with an increase in insulin production. This may leave athletes feeling low later. Athletes should consume a pre-event meal before practice.

Pre-event foods include cereal with skim milk, oatmeal, fresh fruit, juice, toast with jam (no butter), bagel with jam or plain (no butter or cream cheese), pancakes with syrup (no butter), yogurt, and cottage cheese. Liquid meals may be suggested because they usually are high in carbohydrates, include a little fat and protein to promote satiety, contribute to fluid needs, and are rapidly and completely digested.

Snacking is acceptable if it is controlled. Suggested snack foods include low-fat crackers, fruit, cottage cheese, skim or 1 percent milk, pretzels, cooked or raw vegetables, bread with jam/honey/apple butter (no margarine or butter), whole grain cereal with 1 percent milk, frozen yogurt, and ice milk.

FAD DIETS

Athletes are more susceptible to alternative or fad diets than other individuals.

A popular fad diet for athletes is amino acid supplementation to increase strength. Single amino acids taken in large quantities can alter brain neurotransmitters that may cause mood changes. Also, since the body absorbs dipeptides best, many of these amino acids may never be absorbed.

The low-calorie, high-protein, fluid restriction diets that athletes often follow can decrease muscular strength and performance. This type of dieting also may impair cardiac function and body temperature regulation. Forty-one percent of college wrestlers report weight fluctuations of 11 to 20 pounds every week.[5] Gradual weight loss through sound nutritional strategies is necessary to increase the ratio of lean to fat tissue. When crash weight reduction methods are used, primarily lean body weight and water is lost. This causes a decrease in muscle glycogen and water content, decreased endurance, impaired thermoregulation, and impaired cardiac function.

The most critical nutrient for training and performance is water. Optimal physical conditioning depends upon the replacement of fluid losses. Repeated bouts of dehydration may impair kidney function over the short and long term.

Overall, the most efficient way to lose weight is by decreasing dietary fat, increasing consumption of complex carbohydrates, drinking at least two quarts of water daily, limiting alcohol consumption, and exercising on a regular basis.

CONCLUSION

Athletes must have sufficient energy and nutrients to perform well. At least 60 percent of daily calories should come from carbohydrates, less than 25 percent from fat, and 15 percent from protein. Fluid intake must include at least two quarts of noncaffeinated, nonsugar beverages per day. The pre-event meal should be low in fat, high in carbohydrates, and moderate in protein. Energy and protein needs must be met but not exceeded. ■

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Anabolic Steroids: Performance Enhancers?

Richard Levandowski, MD
Vincent K. McInerney, MD
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Physicians must discourage steroid use in those who have not yet begun and must treat those patients already on anabolic steroids. Physicians cannot encourage anabolic steroid use by their patients or by themselves. Anabolic steroids are bad for the user.

Can the use of anabolic steroids by American athletes be as bad as some groups would have physicians and athletes believe? The answer is yes.

All steroids are not alike. We use corticosteroids to treat asthma, allergic reactions, skin problems, and inflammatory conditions. Sex hormone steroids are used for birth control and for postmenopausal women. There is little abuse of these substances by athletes because they tend to be catabolic in nature.

We are concerned about anabolic steroids, derivatives of the male sex hormone testosterone. There is an ever-increasing number of men, women, and boys turning to steroids for "stronger" and "more beautiful" bodies.

The debate over whether anabolic steroids enhance strength and performance is over. Anabolic steroids work. By enhancing a positive nitrogen/potassium retention, enhancing protein synthesis, and blocking the catabolic effect of glucocorticoids, anabolic steroids help to build lean body mass. Muscle mass is gained through water retention.

In individuals who are eating well and involved in weight training programs, the gains in strength can be impressive. The use of steroids allows for increased training by reducing fatigue, increased aggressiveness to attack workouts, or the fast repair and healing of muscles.

Medically, steroids have been successfully used to treat burn victims, cancer and anemia patients, and severely malnourished patients. Some testosterone-deficient men have been helped by supplemental testosterone. These uses are very rare in the average medical practice.

The adverse effects of anabolic steroids far outweigh the benefits of rapid weight gain and strength. Adolescents are particularly at risk for the viriling effects and premature closure of growth plates. Attempts at faster maturation only will backfire with stunted growth.

Most people who take anabolic steroids experience unpleasant skin and hair changes. The skin has an oily appearance with the development of or the worsening of acne. Water retention leads to facial puffiness. There may be a yellow tint to the skin due to the effect on the liver. Women may increase their body hair; both sexes find scalp hair thins with premature balding. There are many sex-dependent changes that take place: breasts enlarge and nipples get redder; women get smaller breasts due to excess testosterone.

Although initially libido increases, the end result seems to be a decrease in sexual functioning. Men suffer with impotence, ejaculatory problems, prostatitis, and decreased and abnormal sperm counts with testicular atrophy. Women develop menstrual irregularities and potentially irreversible deepening of their voices, excess facial hair, and clitoral enlargement.

The effects on the cardiovascular system help to produce a cardiac nightmare. Blood pressure is increased, HDL cholesterol is decreased, and atherogenesis accelerates. Heart disease and strokes are not uncommon in relatively young steroid users. The effects of rapid CV aging are not good.

Kidney function also may be impaired with hematuria and the rare occurrence of Wilm's tumors and other cancers. Similarly, the liver may show decreased excretory function, benign and malignant tumors, and blood-filled cysts.

Although muscle mass increases, bones and tendons remain the same. Therefore, tendons may be torn and bones may be broken due to an overload of the musculoskeletal system. Due to weight gain, excessive pressure can be generated at joint

surfaces to cause a grinding down or fracture of the joint surfaces.

Contrary to the hopes of athletes, steroids do not increase the ability of bones, ligaments, and tendons to heal. Muscle injuries may respond a bit faster on steroids.

Many users undergo an alteration of body perception: they do not like the way they look without taking steroids. An aggressive nature may develop with destructive urges and a sense of invulnerability. Many women have been abused by men using steroids. Violent acts have led to people claiming they were temporarily insane from steroids. Some people have mood swings of euphoria while on the drugs and depression coming off of steroids. This leads to a psychological addiction in those who cannot cope with the depression and changes in body configuration. Psychotic episodes with paranoia, delusions of grandeur, and auditory hallucinations are rare, but do occur.

Anabolic steroids are bad for the user. Their use is illegal in the National Collegiate Athletic Association, the Olympics, and most sports federation activities. Many states have or are in the process of passing laws making it illegal to prescribe anabolic steroids to enhance performance.

Physicians must discourage steroid use in those who have not yet begun and must treat those already on anabolic steroids. We cannot encourage anabolic steroid use by our patients or by ourselves. ■

Requests for reprints may be addressed to Dr. McInerney, 703 Main Street, Paterson, NJ 07503.

DOCTORS' NOTEBOOK

UMDNJ NOTES

Congestive Heart Failure. Adding the latest drug therapy to the standard care of patients with heart failure has cut deaths by 16 percent and significantly reduced hospitalizations. This advance in the treatment of a common cardiac condition, congestive heart failure (CHF), was announced by investigators at the Robert Wood Johnson Medical School of the University of Medicine and Dentistry of New Jersey (UMDNJ), New Brunswick. The medical school was 1 of 23 centers that participated in a four-year major clinical trial conducted in the United States, Canada, and Belgium.

The new treatment, if widely used, could prevent several thousand premature deaths and substantially reduce the number of hospitalizations for CHF.

The study, known as SOLVD—Studies of Left Ventricle Dysfunction, focused on dysfunction of the heart's left ventricle, the lower chamber that propels the blood through the body's circulatory system. Patients in the study were restricted to those who had symptoms of heart failure and whose heart ejected only 35 percent of the blood with each contraction, called ejection fraction; 50 percent or more is normal. The second part of SOLVD, focusing on patients with left ventricular dysfunction who do not have symptoms, is in progress. Dr. John Kostis, chairman of the Department of Medicine at the medical school, is the principal investigator.

AIDS Training Center. UMDNJ has received a $1.6 million federal grant to teach health care workers how to cope with the demands of caring for patients with AIDS. The three-year grant, from the National Institute of Mental Health (NIMH), has been awarded to the Newark-based New Jersey AIDS Education and Training Center in collaboration with UMDNJ-New Jersey Medical School's Department of Psychiatry. The grant is one of four presented nationwide. Dr. Susan Tross, assistant professor of psychiatry, is the principal investigator of the grant. The purpose of the NIMH grant is to design and provide training to health care providers in New Jersey. It will involve learning new ways of thinking about, reacting to, and talking with people with AIDS. Workshops will not be passive learning experiences; they will employ active methods like role playing. This new educational component will be included in all of the 100 programs offered annually by the New Jersey AIDS Education and Training Center. Last year between 5,000 and 7,000 health care professionals attended these programs, which focused on issues like the legal and ethical aspects of AIDS care, medical management and treatment of AIDS patients, and the risks of HIV exposure.

Infant Stress and Illness. Infant "crybabies" who take a long time to quiet down after experiencing

MEETINGS OF THE BOARD OF TRUSTEES of the Medical Society of New Jersey

October 20, 1991
November 17, 1991
December 15, 1991
January 19, 1992
February 9, 1992
March 15, 1992
April 15, 1992

Meetings of the Board of Trustees are open to all physicians. The meeting on March 15, 1992, is an OPEN FORUM, to allow physicians the opportunity to stand up and be heard. If you would like to attend the OPEN FORUM, please contact Diana Gore, MSNJ headquarters, 609/896-1766.

stress are more susceptible to repeated illness than infants who react little to stress, research shows. The research provides parents and physicians with a basis for predicting which babies are in danger of repeated illness in the first two years of life, and it may help them to take preventive measures. Previous research has shown that animals and adult humans who cannot cope effectively with stress are susceptible to diseases of the immune system. The new research is the first to establish a similar link in infants.

The research project involving 110 infants was conducted by Dr. Michael Lewis, professor of pediatrics and psychiatry at UMDNJ-Robert Wood Johnson Medical School.

UMDNJ Champions Sponsor Walkathon. The Champions, UMDNJ's volunteer organization, will hold its second walkathon Sunday, October 6, 1991, to raise money for University-wide AIDS projects. "The Walk of Champions" will take place at noon in both Branch Brook Park in Newark and Cooper River Park in Camden. Registration for the 10K (6.2 miles) walk or the one-mile stroll will begin at 10 A.M. The Champions raise money for special University-related projects and promote the University's educational opportunities and services throughout the state.

Dr. Gallagher Chairs Headache Section. Dr. R. Michael Gallagher, associate dean for clinical affairs at UMDNJ-School of Osteopathic Medicine, has been elected chairperson of the Headache Section of the American Society for Clinical Pharmacology and Therapeutics. As section chair, Dr. Gallagher will oversee the newest advances in drug therapies to treat headaches.

New Associate Dean. Dr. Anthony J. Garro, a noted medical educator and an authority on the effects of alcohol abuse, has been appointed associate dean for academic affairs at UMDNJ-New Jersey Medical School. Dr. Garro also was named professor of microbiology and molecular genetics at the Newark-based school. For the past ten years he was professor and head of microbiology at City University of New York (CUNY) Medical School and its Sophie Davis School for Biomedical Education. ☐ Stanley S. Bergen, Jr, MD

MSNJ AUXILIARY

Recognizing the importance of training our leaders, MSNJ and the Auxiliary are cosponsoring a media training session, entitled, "Medicine and the Media," on September 25, 1991, from 9 A.M. to 12 NOON at MSNJ headquarters.

MSNJ and Auxiliary leaders and other interested physicians, are urged to attend. There is no charge for the workshop. Reservations can be made by calling the Auxiliary office, 609/896-1766. ☐ Marion Geib

FEDERAL LEGISLATORS

The following is a list of current federal legislators and their mailing addresses and telephone numbers. Use this information to write to your legislators.

Senator Bill Bradley
Hart Senate OB, Rm. 731
Washington, DC 20510
(202) 224-3224

Senator Frank R. Lautenberg
Hart Senate OB, Rm. 717
Washington, DC 20510
(202) 224-4744

Robert E. Andrews (D)
Rayburn HOB, Rm. 2162
Washington, DC 20515
(202) 225-6501

Bernard J. Dwyer (D)
Rayburn HOB, Rm. 2428
Washington, DC 20515
(202) 225-6301

Dean A. Gallo (R)
Longworth HOB, Rm. 1318
Washington, DC 20515
(202) 225-5034

Frank J. Guarini (D)
Rayburn HOB, Rm. 2458
Washington, DC 20515
(202) 225-6572

William J. Hughes (D)
Cannon HOB, Rm. 341
Washington, DC 20515
(202) 225-6572

ARE YOU MOVING?

If so, please send a change of address to *NEW JERSEY MEDICINE*, Medical Society of New Jersey, Two Princess Road, Lawrenceville, NJ 08648, at least six weeks before you move.

Name _____

Old Address _____

City _____ State _____ Zip _____

New Address _____

City _____ State _____ Zip _____

Frank Pallone, Jr (D)
Longworth HOB, Rm. 1207
Washington, DC 20515
(202) 225-4671

Donald M. Payne (D)
Cannon HOB, Rm. 417
Washington, DC 20515
(202) 225-3436

Matthew J. Rinaldo (R)
Rayburn HOB, Rm. 2469
Washington, DC 20515
(202) 225-5361

Robert A. Roe (D)
Rayburn HOB, Rm. 2243
Washington, DC 20515
(202) 225-5751

Marge Roukema (R)
Cannon HOB, Rm. 303
Washington, DC 20515
(202) 225-4465

Jim Saxton (R)
Cannon HOB, Rm. 324
Washington, DC 20515
(202) 225-4765

Christopher H. Smith (R)
Cannon HOB, Rm. 2440
Washington, DC 20515
(202) 225-3765

Robert G. Torricelli (D)
Cannon HOB, Rm. 317
Washington, DC 20515
(202) 225-5061

Dick Zimmer (R)
Rayburn HOB, Rm. 2422
Washington, DC 20515
(202) 225-5801

PLACEMENT FILE

The following physicians have written to the executive offices of MSNJ seeking information on opportunities for practice in New Jersey. If you are interested in information concerning these physicians, we suggest you make inquiries directly to them.

Cardiology

George D. Birmingham, MD, 3531 Salerno Ct., Apt. 5, Middleton, WI 53562. Mount Sinai 1984. Board eligible. Board certified (IM). Group or partnership. Available.

Family Medicine

Vicente F. Franco, MD, 9362 Bay Colony Dr., Apt. 1S, Des Plaines, IL 60016. Universidad Central del Este 1982. Board eligible. Available.

Internal Medicine

Thomas P. Hooker, DO, 2804 Sitios St., Tampa, FL 33629. Philadelphia College of Osteopathic Medicine 1984. Board certified; also, PUL. Solo or multispecialty group. Available.

Marc Kesselhaut, MD, 1 Rustic Ridge, C16, Little Falls, NJ 07424. St. George's University 1986. Board eligible. Solo or partnership in Mercer, Somerset, Burlington, Hunterdon, or Middlesex counties. Available.

M. Stekelman, MD, P.O. Box 900, Hightstown, NJ 08520. BSAS (Argentina) 1959. Also, gastroenterology. Board eligible. Outpatient or ambulatory facility. Available.

Nephrology

Vinitha Raj, MD, 82-30 26th St., Floral Park, NY 11204. Guntar Medical School (India) 1981. Board eligible. Board certified (IM). Group or partnership.

Obstetrics/Gynecology

Dennis Tumbokonm, MD, P.O. Box 476, Kimball, WV 24853. University of the East. Board eligible. Solo. Available.

Pediatrics

Donna Churlin, MD, 55 Montgomery St., Bloomfield, NJ 07003. UMDNJ 1987. Board eligible. Partnership or group in central New Jersey (Essex, Union, or Morris counties). Available.

Radiation Oncology

Carol L. Kornmehl, MD, 133 Wyncrest Rd., Marlboro, NJ 07746. SUNY-Downstate 1984. Board certified. Group, partnership, solo. Available.

Surgery

Nichlas J. Dudas, MD, 915 Princeton Ave., Philadelphia, PA 19111. UMDNJ 1986. Board eligible. Group or partnership. Available.

MEDICINE AND THE MEDIA

September 25, 1991

The Medical Society of New Jersey and the Auxiliary of the Medical Society of New Jersey are cosponsoring the following program:

9:00 A.M.-9:30 A.M.	Registration
9:30 A.M.-11 A.M.	***How To Present Yourself in Public*** Jane Coughlin Director, Internal Communications, AMA
11 A.M.-11:15 A.M.	Questions and Answers
11:15 A.M.-11:45 A.M.	***Newspaper Coverage of Medical Topics: How To Get Medical Services Recognized in the Community*** Vani Rangachar Health Editor, Asbury Park Press
11:45 A.M.-12 Noon	Questions and Answers
12 Noon	Luncheon

DEBORAH HEART AND LUNG CENTER

DEPARTMENT OF PULMONARY MEDICINE

PRESENTS

EIGHTH ANNUAL CLINICAL UPDATE IN PULMONARY MEDICINE

Saturday, December 7, 1991
Caesars Atlantic City
Atlantic City, New Jersey

Designed for Family Practitioners, Internists, Pulmonologists, and Allied Health Care Professionals

8 Hours Category 1 CME Credit
Spouse Program/Optional Activities

PROGRAM

Acute Pulmonary Embolism ..... Roger Bone, MD

Radiology of the Pneumoconioses ..... William K.C. Morgan, MD

The Clara Falk Franks Lecture - Respiratory Failure and Multi-organ Failure: New Concepts ..... Roger Bone, MD

Asbestosis and Asbestos-Related Pleural Disease ..... William K.C. Morgan, MD

Hypersensitivity Pneumonitis ..... David Murphy, MD

Acute Respiratory Failure in Chronic Obstructive Pulmonary Disease ..... Thomas Petty, MD

Community Acquired Pneumonia-1991 ..... John Bartlett, MD

Newer Approaches to Asthma Management ..... Thomas Petty, MD

Opportunistic and Nosocomial Pulmonary Infections ..... John Bartlett, MD

Drug-Induced Lung Disease: A Microcosm of Pulmonary Medicine ..... Mervyn Feierstein, MD

For information contact :
Center for Bio-Medical Communication, Inc.
80 West Madison Avenue, Dumont, NJ 07628 (201) 385-8080

SEMINAR ON

TERATOLOGY & TECHNIQUES OF PRENATAL DIAGNOSIS

Presented by

**SETON HALL UNIVERSITY—
SCHOOL OF GRADUATE MEDICAL EDUCATION
SOUTH ORANGE, NEW JERSEY**

Department of Obstetrics & Gynecology
Peter A. Beaugard, M.D., *Chairman*

Saturday, October 26, 1991
8:30 a.m.-4:00 p.m.
Ramada Plaza-Suite Hotel
350 Route 3 West, Secaucus, NJ 07094

Occupational Hazards & Teratology
Howard Kipen, M.D., M.P.H.
Robert Wood Johnson Medical School
Piscataway, New Jersey

Medications & Teratogens
Karin Blakemore, M.D.
John Hopkins Medical Institution
Baltimore, Maryland

Infections as Teratogens
John Sever, M.D.
Childrens Hospital
Washington, D.C.

Chorionic Villus Sampling & Amniocentesis
Joseph Schulman, M.D.
Medical College of Virginia
Fairfax, Virginia

Alpha-fetoprotein Screening
Marion Verp, M.D.
University of Chicago
Chicago, Illinois

For additional information and registration please contact:

Lillian Paiumbo, Ph.D., R.N.
Seton Hall University
School of Graduate Medical Education
South Orange, NJ 07079-2689
Telephone: (201) 761-9631

The AMERICAN COLLEGE OF OBSTETRICIANS & GYNECOLOGISTS has assigned 6 cognates (Formal Learning) to this program.

SETON HALL UNIVERSITY SCHOOL OF GRADUATE MEDICAL EDUCATION is accredited by the Medical Society of New Jersey to sponsor continuing medical education for physicians.

SETON HALL UNIVERSITY SCHOOL OF GRADUATE MEDICAL EDUCATION designates this continuing medical education activity for 6 credit hours in Category 1 of the Physicians Recognition Award of the AMA.

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Acupuncture & Electro-Therapeutics in Clinical Practice

New York State Boards of Medicine & Dentistry 25-hour accredited seminar & workshop on latest theories & techniques of manual & electro-acupuncture, TENS & simple non-invasive diagnostic methods (including cardio-vascular, neuromuscular, central nervous systems & "Bi-Digital O-Ring Test"), applicable towards 300-hour requirement for certification to practice acupuncture, will be given periodically for licensed clinicians (with or without prior training) on 3-day weekends (Fri-Sun) of Sept. 20-22, Nov. 22-24, and Dec. 13-15, 1991, at Milford Plaza Hotel, 45th St. & 8th Ave., New York City.

The 7th Annual International Symposium on Acupuncture & Electro-Therapeutics will be held at Columbia University, School of International Affairs, 420 W. 118th St., N.Y. City, during October 17-20, 1991.

These meetings are co-sponsored by the International College of Acupunture & Electro-Therapeutics & its official journal, Acupuncture & Electro-Therapeutics Research, The International Journal (published by Pergamon Press & indexed in 15 major indexing periodicals, including Index Medicus), Heart Disease Research Foundation; NY Pain Center; Electrical Engineering Dept., Manhattan College; Nordic Medical Acupuncture Society (Scandinavia); Schmerz Therapeutische Kolloquium (West Germany); Japan Bi-Digital O-Ring Test Assn.; Accredited toward Acupuncture Certification to practice acupuncture. Eligible for AMA CME Cat. I credit (about 40 credit-hours for the Symposium).

For information on meetings or submission or presentations of papers, contact Symposium Chairman, Prof. Y. Omura, M.D., Sc.D., 800 Riverside Drive (8-I) New York, NY 10032 Tel: (212) 781-6262 (10 am to 10 pm 7 days a week) or (212) 928-0658, Co-chairman, Prof. A.W. Cook, MD (516) 877-1821, or Bro. Michael Losco (212) 920-0162.

Investment and Retirement Planning Workshop

We invite you to attend our unique one-day workshop. Our experts will show you what you should know about taxes, investments, and money management to maintain your lifestyle through retirement.

We will introduce you to concepts and practices that will help make your retirement more comfortable.

Learn how to make the right choices when confronted with inflation, investment alternatives, rising health care costs and estate planning issues.

The fee is $175 for Members and $195 for Non-Members. The fee includes lunch, workbook, and individual analysis.

To register, call **1-800-523-0864.** The presentation begins promptly at 9:00 a.m. and ends at 4:00 p.m. Registration begins at 8:30 a.m. Seating is limited, so call today!

AMA Investment Advisers, Inc.

The Financial Services and Investment Counseling Organization
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UPCOMING SEMINARS IN YOUR AREA:

The Medical Society of the State of New Jersey
Two Princess Road, Lawrenceville, NJ
Wednesday—September 11 *or* Wednesday—November 6

CONTINUING EDUCATION

INFECTIOUS DISEASE

October

2 Diagnosis and Treatment of AIDS
9-10 A.M.—Warren Hospital, Phillipsburg
(AMNJ and NJDOH)

16 AIDS Training and Resource Program for Hospital Health Educators
10:30-11:30 A.M.—St. Mary's Hospital, Passaic
(AMNJ)

21 Diagnosis and Treatment of AIDS
1-2 P.M.—New Lisbon Developmental Center, New Lisbon
(AMNJ and NJDOH)

31 Diagnosis and Treatment of AIDS
1-2 P.M.—James J. Howard VA/Op Clinic, Trenton
(AMNJ and NJDOH)

MEDICINE

October

2 Thyroid Diseases
10:30-11:30 A.M.—St. Mary's Hospital, Passaic
(AMNJ)

2 Sports Medicine Update
8:30-12:30 P.M.—MSNJ, Lawrenceville
(MSNJ)

3 Appropriate Fluid IV Ordering, Electrolyte and Fluid Balance
12 Noon-1 P.M.—Community Medical Center, Toms River
(Community Medical Center)

4-5 Communication Enhancement Training Program
All day—Marriott Seaview, Absecon
(MIIENJ)

8 Public Health Screening Tests
12:15-1:30 P.M.—John Fitch Plaza, Trenton
(NJDOH)

9 Peptic Ulcer Disease
10:30-11:30 A.M.—St. Mary's Hospital, Passaic
(AMNJ)

11 Multiple Sclerosis
12 Noon-1 P.M.—South Jersey Hospital System, Bridgeton
(AMNJ)

15 Renovascular Occlusive Disease and Renal Failure
6:15-7:15 P.M.—Overlook Hospital, Summit
(Nephrology Society of NJ)

16 Grand Rounds
11:30 A.M.-12:30 P.M.—Newcomb Medical Center, Vineland
(Newcomb Medical Center)

16 The Ventilator Dependent Child
8 A.M.-4 P.M.—Children's Specialized Hospital, Mountainside
(Children's Specialized Hospital)

17 Tumor Board Conference
12:15-1:15 P.M.—Mercer Medical Center, Trenton
(Mercer Medical Center)

17 Diabetic Nephropathy
1-2 P.M.—James J. Howard VA/Op Clinic, Trenton
(AMNJ)

19 Diabetes-Related Cardiovascular Disease
1-2 P.M.—VA Medical Center, Lyons
(AMNJ)

22 Primary Care Directions
12:15-1:30 P.M.—John Fitch Plaza, Trenton
(NJDOH)

23 Geriatrics: Camouflaged Medical Illness
10:30-11:30 A.M.—St. Mary's Hospital, Passaic
(AMNJ)

23 Medical Education Conference
8:30 A.M.-3:30 P.M.—Medical Society of New Jersey headquarters, Lawrenceville
(MSNJ, NJ Association of Hospital Directors of Medical Education, UMDNJ, and AMNJ)

23 Medication Awareness
All day—Howard Johnson, Secaucus
(Hudson County Medical and Pharmaceutical Societies)

24 Anaerobic Infections
12 Noon-1 P.M.—Community Medical Center, Toms River
(Community Medical Center)

24 Surgical Grand Rounds: How To Deal with Postaneurysm Reconstruction Complications
5-6 P.M.—Shore Memorial Hospital, Somers Point
(Shore Memorial Hospital)

30 Pediatric Pulmonary Seminar
8 A.M.-3 P.M.—Holiday Inn, Jamesburg
(New Jersey Thoracic Society)

November

7 Multiple Sclerosis: Treatment Approaches
6-9 P.M.—Welkind Rehabilitation Hospital, Chester
(Welkind Rehabilitation Hospital)

11 Diabetic Nephropathy
7-8 P.M.—Wallkill Valley General Hospital, Sussex
(AMNJ)

14 Prevention of Platelet Dysfunction by the Use of Leucocyte Removal Filters
11 A.M.-12:30 P.M.—St. Joseph's Hospital and Medical Center, Paterson
(St. Joseph's Hospital and Medical Center)

20 Dermatology Conferences
6-9 P.M.—Rutgers Community Health Plan, New Brunswick
(UMDNJ)

21 Tumor Board Conference
12:15-1:15 P.M.—Mercer Medical Center, Trenton
(Mercer Medical Center)

Hahnemann University

Department of Medicine Grand Rounds
Wednesdays 8:30 a.m.-9:30 a.m.

Sept.-Dec. 1991

September 1991

September 4, 1991
PHARMACOLOGIC THERAPY AFTER MYOCARDIAL INFARCTION
William W. Parmley, M.D.
Professor of Medicine
Chief, Division of Cardiology
Moffett/Long Hospital
San Francisco, CA

September 11, 1991
GRANULOCYTE MACROPHAGE COLONY STIMULATING FACTOR (GMCSF)
John Nemunaitis, M.D.
Assistant Professor of Medicine
Division of Hematology & Oncology
Fred Hutchinson Cancer Center
University of Washington
Seattle, WA

September 18, 1991
Yom Kippur—No Grand Rounds

September 25, 1991
HEMODYNAMIC DERANGEMENT OF SEPSIS: THE PROBLEM AND SOLUTION?
R. Phillip Dellinger, M.D., M.Sc.
Associate Professor of Medicine
Director, Critical Care
Department of Medicine
Baylor College of Medicine
Houston, TX

October 1991

October 2, 1991
NSAIDS: MECHANISMS OF ACTION AND ADVERSE REACTIONS
William M. O'Brien, M.D.
Professor of Medicine
Division of Rheumatology
University of Virginia
Charlottesville, VA

October 9, 1991
GENE ACTIVATION AND CYTOKINES IN PULMONARY INFLAMMATION & FIBROSIS
John A. McDonald, M.D.
Professor of Medicine, Biochemistry and Molecular Biology
Mayo Medical School
Director of Research
Mayo Clinic, Scottsdale
Scottsdale, AZ

October 16, 1991
CARDIAC ELECTROPHYSIOLOGY AND IMAGING
Scott E. Hessen, M.D.
Assistant Professor of Medicine
Division of Cardiology, Hahnemann University
Charles C. Nydegger, M.D.
Assistant Professor of Medicine
Division of Cardiology, Hahnemann University
Steven P. Kutalek, M.D.
Assistant Professor of Medicine
Director, Clinical Cardiac Electrophysiology
Division of Cardiology, Hahnemann University

October 23, 1991
HLA-B27—PAST, PRESENT AND FUTURE
James Louie, M.D.
Professor of Medicine
Chief, Division of Rheumatology
Department of Medicine
Harbour-UCLA Medical Center
Torrence, CA

November 1991

November 6, 1991
TREATMENT OF HYPERLIPIDEMIA
David Bilheimer, M.D.
Professor of Medicine
University of Texas
Southwest Medical Center
Dallas, Texas

November 13, 1991
DIAGNOSIS AND TREATMENT OF BREAST CANCER
Isadore Brodsky, M.D.
Professor and Chairman
Department of Neoplastic Diseases
Hahnemann University
S. Benham Kahn, M.D.
Professor of Neoplastic Diseases
Department of Neoplastic Diseases
Hahnemann University

November 20, 1991
TREATMENT OF OSTEOPOROSIS
Robert Lindsay, M.D., Ph.D.
Professor of Clinical Medicine
Columbia University College of Physicians and Surgeons
Chief, Internal Medicine
Helen Hayes Hospital, NY

November 27, 1991
AIDS AND CARDIOVASCULAR COMPLICATIONS OF SUBSTANCE ABUSE
Vincent Zarro, M.D., Ph.D.
Professor of Medicine
Director, Division of Clinical Pharmacology
Hahnemann University

December 1991

December 4, 1991
DIASTOLIC MECHANISMS OF HEART FAILURE
Robert O. Bonow, M.D.
Chief, Nuclear Cardiology
Deputy Chief, Cardiology Branch
NHLBI, Bethesda, MD

December 11, 1991
THYROTOXICOSIS: A SPECTRUM OF DISEASE
Lewis E. Braverman, M.D.
Professor of Medicine and Physiology
Director, Division of Endocrinology
University of Massachusetts

December 18, 1991
IMMUNOLOGY AND RHEUMATOLOGY CLINICAL RESEARCH
Lawrence H. Brent, M.D.
Assistant Professor of Medicine
Division of Immunology and Rheumatology, Hahnemann University
Carolyn H. McGrory, R.N., M.S.
Clinical Nurse Specialist
Division of Immunology and Rheumatology, Hahnemann University

December 25, 1991
No Grand Rounds

Hahnemann University Department of Medicine
Wednesday Medical Seminar Series
8:30 a.m.-3:30 p.m.

September 25, 1991
SEPTIC SHOCK AND CRITICAL CARE

October 9, 1991
PULMONARY DISORDERS OF INFLAMMATION AND FIBROSIS

November 6, 1991
TREATMENT OF HYPERLIPIDEMIA

November 13, 1991
DIAGNOSIS AND TREATMENT OF BREAST CANCER

November 20, 1991
TREATMENT OF OSTEOPOROSIS AND METAGOLIC BONE DISEASE

Seminar Directors:

William S. Frankl, M.D.
Professor of Medicine and Chairman
Department of Medicine

Allan B. Schwartz, M.D.
Professor of Medicine
Director, Continuing Medical Education for the Department of Medicine

Location:

Classroom C (Alumni Hall)
2nd Floor New College Building
Hahnemann University 15th Street Entrance
15th & Vine Streets
Philadelphia, PA

As an organization accredited by the Accreditation Council for Continuing Medical Education (ACCME), Hahnemann University designates this continuing medical education activity as Category 1 of the Physician's Recognition Award of the American Medical Association. One credit hour may be claimed for each hour of participation by the individual physician.

For information, call the Office of Continuing Education at (215) 448-8263

October

3 **Asthma/COPD: Update for Psychiatrists**
12 Noon-1 P.M.—Carrier Foundation, Belle Mead
(Carrier Foundation)

10 **Alcohol, Suicide, and Depression**
12 Noon-1 P.M.—Carrier Foundation, Belle Mead
(Carrier Foundation)

17 **Group Therapy with Adult Children of Alcoholics**
12 Noon-1 P.M.—Carrier Foundation, Belle Mead
(Carrier Foundation)

23 **Bipolar Illness**
All day—Carrier Foundation, Belle Mead
(Carrier Foundation)

31 **Dual Diagnosis: An Update**
12 Noon-1 P.M.—Carrier Foundation, Belle Mead
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November

7 **Neurobiology of Abused Drugs**
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13 **Mental Health and the Law**
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14 **Pharmacotherapy of Dysthymia**
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IN MEMORIAM

WILLIAM O. GREEN, JR

At the age of 64, William Oliver Green, Jr, MD, passed away on May 8, 1991. Dr. Green was born in Washington, DC, on March 15, 1927, and was awarded his medical degree from George Washington University School of Medicine, Washington, DC, in 1952. He completed an internship at Henry Ford Hospital, Michigan, and residencies at George Washington University Hospital, Washington, DC, and at Veterans Administration Hospital, Durham, North Carolina. Dr. Green received his Washington, DC; Tennessee; Texas; and New Jersey medical licenses in 1954, 1960, 1961, and 1964, respectively. Dr. Green was a member of our Bergen County component, of the American Medical Association, and of the Tennessee and Texas medical societies; a diplomate of the American Board of Clinical Pathology and of the American Board of Pathologic Anatomy; and a fellow of the College of American Pathologists and of the American Society of Clinical Pathology. Dr. Green served in the United States Army Medical Corps from 1955 to 1956. Dr. Green was assistant professor and director of surgical pathology at the University of Texas, Galveston, Texas; later, he was a pathologist at Professional Medical Laboratory, Ridgewood, and served for many years as director of pathology at The Valley Hospital, Ridgewood. He resided in Mahwah, Franklin Lakes, and Ramsey.

LOUIS KOSMINSKY

Louis Kosminsky, MD, passed away on April 24, 1991. Born in 1904, Dr. Kominsky graduated with a medical degree from St. Andrews University, Scotland, in 1935. Dr. Kosminsky received his New Jersey medical license in 1936. A family practitioner, Dr. Kosminsky maintained a practice in West New York and resided in Fort Lee. Dr. Kosminsky was affiliated with Christ Hospital, Jersey City, and with North Hudson Hospital, Weehawken. He was a member of the American Medical Association and of our Hudson County component; vice-president of the New Jersey Academy of General Practice; and president of the North Hudson Physician's Society. Dr. Kosminsky served in the United States Army Medical Corps as a transport surgeon during World War II, receiving two Bronze Star medals for his efforts.

EDWARD J. SUROWIEC

Born in Margonin, Poland, on January 12, 1923, Edward James Surowiec, MD, died on May 2, 1991. Dr. Surowiec was awarded his medical degree from Georgetown University School of Medicine, Washington, DC, in 1947, and received his New Jersey medical license in 1956. He practiced obstetrics and gynecology in Trenton since 1957, and was senior attending at Helene Fuld Medical Center, Trenton, and at Hamilton Hospital, Hamilton. Dr. Surowiec served in the United States Army Medical Corps from 1952 to 1954. Dr. Surowiec was a member of our Mercer County component and of the American Medical Association; and a fellow of the International College of Surgeons and of the American College of Obstetricians and Gynecologists.

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CONTENT

NEW JERSEY MEDICINE is the official organ of the Medical Society of New Jersey. The goals are educational and informational. All material published is copyrighted by the Medical Society of New Jersey.

The educational contents of each issue appear as scientific articles, based on research, original concepts relative to epidemiology of disease, and treatment methodology; case reports; review articles; clinical notes; state of the art reports; and special articles, that include evaluations, policy and position papers, and reviews of nonscientific subjects. Other topics include professional liability commentary; critical narration; medical history; pediatric briefs; nutrition update; and opinions. Editorials are prepared by the editor and by guest contributors on timely and relevant subjects. The Doctors' Notebook section contains organizational and administrative items from the Medical Society of New Jersey and from the community. Letters to the editor and book reviews are welcome and will be published as space permits.

The principal aim in the preparation of a contribution should be relevance to diagnosis and treatment and to the education of patients and professionals. Preference will be given to authors from New Jersey and to out-of-state lecturers submitting a suitable manuscript based on a presentation made to an audience in New Jersey.

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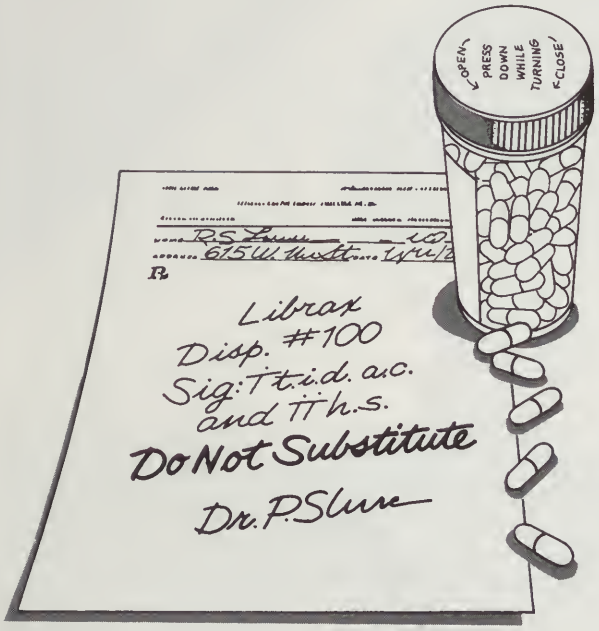
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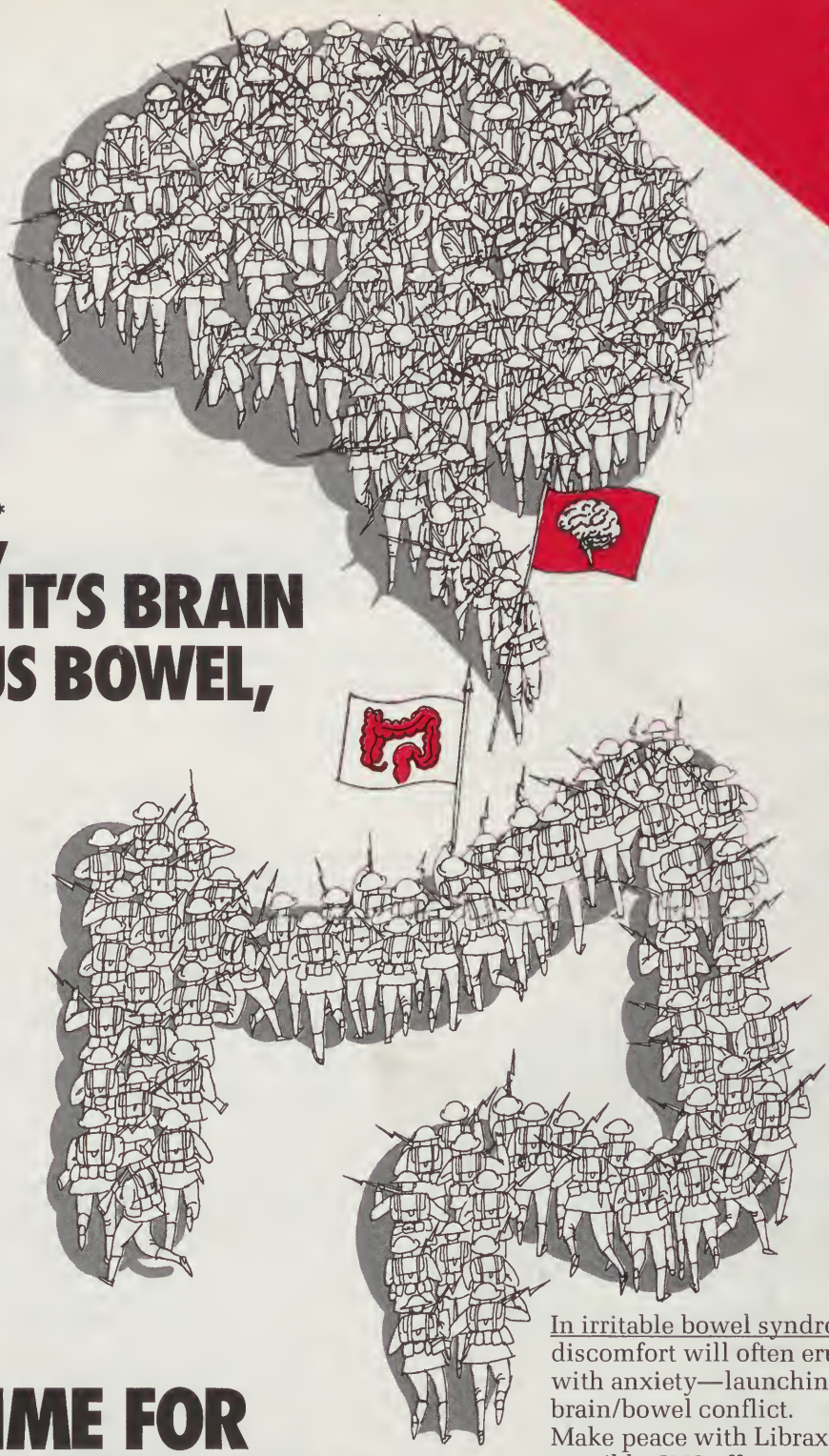
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PHYSICIAN ASSISTANTS: NO...

A special session of the MSNJ House of Delegates was convened on September 15, 1991. The House overwhelmingly voted to continue opposition to the licensing and use of physician assistants. The action requires MSNJ to oppose any legislation that would authorize the use of physician assistants.

The State Board of Medical Examiners has adopted and is implementing a regulation that authorizes the use of physician assistants. MSNJ has filed a lawsuit challenging the legality of the Board action.

MEDICARE--RBRVS...

Confusion continues over the January 1992 Medicare fee schedule. An angry Congress directed the Health Care Financing Administration (HCFA) to restore the 16 percent in cuts it had modeled. It is not clear whether HCFA will respect congressional direction. MSNJ has been advised that HCFA will announce its decision very soon. Regardless of the restoration of the 16 percent factor, it is evident that in January 1992 many physicians will see reductions in their fees under the Medicare program compared to 1990 and 1991 levels.

BLOOD TRANSFUSIONS--CHART NOTATION...

A recently enacted state law provides that whenever a blood transfusion may be necessary during a surgical procedure, the patient must receive prior notification of the option of autologous transfusion, designated transfusion, or homologous transfusion. This requirement of notification must be recorded in the patient's medical record. The foregoing requirements are waived if the surgery is on an emergency basis or if there are medical contraindications. The law became effective on September 6, 1991.

October 1991

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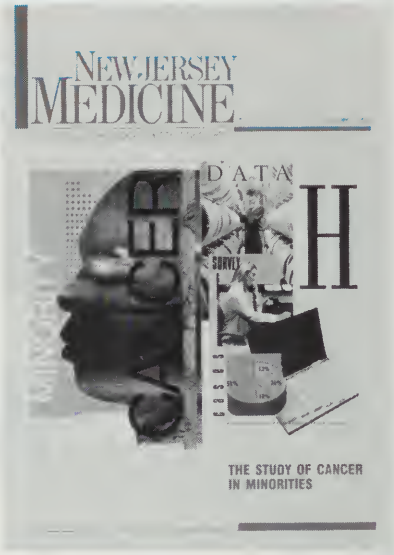
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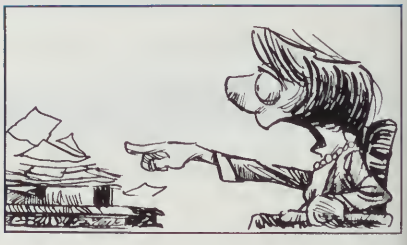
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Reference volumes listing databases for studying cancer in minorities is our cover story, beginning on page 713. Cover: Williams & Philips.

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MSNJ NEWSLETTER

MEDICARE FRAUD ALERT ON WAIVER OF COINSURANCE

A recent Medicare bulletin included a fraud alert concerning the waiver of Medicare deductibles and coinsurance. This alert, from the inspector general's office of the Department of Health and Human Services, indicated that routine waiver of Medicare patient liability by physicians and suppliers of medical equipment and services may violate federal anti-kickback and false claim laws. The vast majority of physicians need not worry about occasionally deciding not to press for patient payment of the deductible or coinsurance if that decision is based on the patient's financial condition. To avoid any question of a violation of the Medicare statute in such cases, physicians can follow a few simple principles:

1. Do not advertise your practice as one that routinely accepts the Medicare allowance as payment in full for services performed.

2. Provide each patient with a bill and attempt to collect the coinsurance from the patient or other third-party payer.

3. Do not charge Medicare patients higher amounts than other patients.

4. If you waive the coinsurance or deductible in an individual case, make sure your action is based on the patient's financial condition.

It is not required that physicians make extraordinary attempts to collect from the patient. In those cases where a bill has been issued but the cost of continuing collection efforts could exceed or be disproportionate to the amount to be collected from a particular patient, the physician need not continue to press the patient for payment. To be considered a reasonable collection effort, the effort to collect Medicare coinsurance and deductible amounts must be similar to that made to collect comparable amounts from non-Medicare patients.

Physicians who follow these principles should not have a problem with violation of the federal anti-fraud rules. □

Maurice Hartman, Regional Administrator, Health Care Financing Administration

AMA ADVISORS: HIGHER EDUCATION COSTS

By the year 2000, tuition for four undergraduate years at a public university could cost almost $20,000. This is a modest sum when compared to the skyrocketing prices of private and Ivy League schools.

But before you panic and enroll your tots in trade school, there are some very basic investment strategies you could use to help finance higher education.

Mutual Funds. There are literally hundreds of investment opportunities available, some simple, others more sophisticated. Many Americans now are turning to mutual funds as an investment vehicle for a variety of reasons, including relative ease of investing and convenience.

Mutual funds are a popular choice because they offer professional management, diversification, liquidity, and systematic investing.

Systematic investing simply is investing a set amount of money on a regular basis. It is an easy investment strategy that takes advantage of compounding and dollar cost averaging.

The most common application of compounding is compound in-

terest, such as interest on a loan. The amount of money you borrow in student loans, for example, will grow through compound interest that will have to be paid back.

But you can make compounding work for you instead of against you when investing in mutual funds. The money you invest today can compound, or grow, as long as it is reinvested. It is important to leave the money invested as long as possible, to let it compound.

For example, consider the following investment: $100 monthly for 18 years at 8 percent yields $48,000; $250 monthly for 10 years at 8 percent yields $45,740.

Another simple sophisticated investment concept is called dollar cost averaging. Rather than trying to time the highs and lows of the stock market, a difficult task for even the most sophisticated professional investor, dollar cost averaging turns the ups and downs of the stock market into an advantage, so the state of the market when you enter or exit does not matter. In other words, there is no bad time to begin investing.

By investing on a regular basis, no matter how large or small the amount, you may purchase more shares for less than average market cost over a specific time period. Consistent, systematic investing may be the most dependable and most convenient investment strategy.

Investing. Assume, for example, you invest $100 each month and the fund in which you have invested sells for $10 per share. (For this hypothetical example, let us assume there are no additional charges.) You invest $100 and receive 10 shares. The next month, taking an easy but extreme example to follow, the fund goes down to $5 per share. You invest $100 for that month and buy 20 shares. The following month, the fund price skyrockets to $10 per share. With your monthly investment, you buy 10 shares. After a total investment of $300, you now own 40 shares. However, with an ending price of $10 per share, your shares actually are worth more than you paid for them.

The average price per share over three months ($25 divided by 3 months) was $8.33, but the average cost to you ($300 divided by 40 shares) was $7.50.

Of course, no program can guarantee a profit or protect against losses in a declining market, but dollar cost averaging has proved to be a valuable system when pursued faithfully. Together with the profit of compounding reinvested monies, systematic investing may lessen the fear of the formidable cost of higher education.

Systematic investing is an easy way to obtain what may be the most profitable investment you will make for yourself or for your child: a college education.

For more information on dollar cost averaging, systematic investing, or the advantages of mutual funds as a savings vehicle, call AMA Investment Advisers, 1/800/523-0864. □

CALLING ALL MEDICAL MUSICIANS

VA-National Medical Musical Group (VA-NMMG) is recruiting new members for its chorus and symphony orchestra. If you are a good singer or play a musical instrument, you could join the group. VA-NMMG gave a highly acclaimed Christmas concert last December at Constitution Hall in Washington, DC, to benefit homeless veterans. Medical musicians came to the Capitol from 23 states. The performance was a great success and won a favorable review from the *Washington Post.* This year VA-NMMG will play on December 4, 1991. Membership is open to physicians, nurses, other medical personnel, and medical students. Please contact: VA-NMMG, 1700 NW 17th Street, Suite 508, Washington, DC 20009.

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	William E. Ryan, MD
	Robert J. Weierman, MD
April 27	Joel S. Cherashore, MD
	Douglas M. Costabile, MD
	Paul J. Hirsch, MD
	Donald J. Holtzman, MD
	A. Ralph Kristeller, MD
	Joseph N. Micale, MD
	Irving P. Ratner, MD
	Carl Restivo, Jr, MD
	William E. Ryan, MD
	Robert J. Weierman, MD
May 1	Joel S. Cherashore, MD
	George T. Hare, MD
	Paul J. Hirsch, MD
	Donald J. Holtzman, MD
	A. Ralph Kristeller, MD
	Mark T. Olesnicky, MD
	Irving P. Ratner, MD
June 9	Joel S. Cherashore, MD
	Douglas M. Costabile, MD
	George T. Hare, MD
	Paul J. Hirsch, MD
	Donald J. Holtzman, MD
	A. Ralph Kristeller, MD
	Mark T. Olesnicky, MD
	Irving P. Ratner, MD
	Carl Restivo, Jr, MD
	Robert J. Weierman, MD

CLIA 88 UPDATE

Federal legislators are making headway with the implementation of the Clinical Laboratory Improvement Amendments (CLIA) of 1988.

Congress charged that the Health Care Financing Administration had failed to provide appropriate information by not completing the five studies that were to be the basis of the regulations.

The two areas undergoing major renovations are the three tier test levels and the personnel and director requirements. The American Medical Association (AMA) has asked for an addition of a test level "A" that would be unique to physician office laboratories (POLs). Proficiency testing still would be required for all the level "A" tests. The College of American Pathologists has continued to oppose the personnel standards below the technical supervisor stating that POLs would find it extremely difficult, if not impossible, to meet the present requirements and be forced to close. In rural areas this would be a serious problem. Equivalency routes for POL personnel are being proposed.

Dr. Wilensky has told Congress that the ultimate goal is to "weigh all the comments and try to find accommodation for the small laboratories without compromising the quality of laboratory testing." HCFA has released the following timetable for main CLIA components and for full implementation of the law: User Fees: imminent at present time; Accreditation: October 1991; Complexity Model: Winter 1991-1992; Sanctions/Penalties: Winter 1991-1992; and Full Implementation: May 1992.

REPORTING BY TELEPHONE

Licensed physicians reporting a colleague's impairment, in accordance with requirements of the Medical Conduct Reform Act, may contact the State Board of Medical Examiners' president, Sanford Lewis, MD, at 201/994-1144, or vice-president, Fred M. Jacobs, MD, at 201/533-5611. These numbers are to be used only for this purpose. □

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PROFESSIONAL LIABILITY

CORRECTION

In August, these pages reflected a misunderstanding of a New Jersey malpractice case involving the birth of twins. The commentary stated that the "second twin presented in face mentum posterior position," and that "high forceps were used in the delivery." A closer examination of the facts has revealed a disparity in the medical record as to whether the position was mentum posterior or mentum transverse. In addition, the defense maintained that high forceps were used to flex the head, not to deliver the baby. A cesarean section was performed, and the baby was diagnosed with bilateral Klumpke's paralysis, perhaps caused in utero. The verdict in favor of the plaintiff has been appealed. The authors regret their misunderstanding.

LICENSE SUSPENSION

What constitute "repeated acts of negligence" sufficient to justify the State Board of Medical Examiners (SBME) suspension of a physician's license to practice? That question was addressed in April by the Appellate Division of the Superior Court of New Jersey, and the question is likely to come before the court again in the same case.

The case involves administration of general anesthesia during an abortion performed at a private clinic in 1985. The anesthesia was administered by a nurse-anesthetist, whose conduct presumably was negligent in several particulars. After a lengthy hearing conducted by an administrative law judge, SBME suspended the license of the anesthesiologist who served as the clinic's director of anesthesiology at the time of the procedure.

Coloring the case is a tragic outcome: The 16-year-old patient, apparently in good health at the outset, lapsed into a coma immediately following the procedure; she died ten weeks later. Death was attributed to pneumonia and terminated a hospital stay punctuated by infection, a tracheostomy and gastrostomy, and a finding that the patient's condition was consistent with severe brain damage, most likely caused by ventilatory failure.

Multiple errors of omission and commission were attributed to the nurse-anesthetist:

1. Failure to prepare the patient for anesthesia by removing the patient's makeup and jewelry, a failure that made subsequent evaluations of the patient's condition problematic.
2. Deviation from accepted standards of practice by failing to use a stethoscope or blood pressure cuff during the procedure.
3. Failure to take the patient's blood pressure before the procedure (the nurse-anesthetist merely relied on a statement that the patient's blood pressure was normal).
4. Numerous recording errors, including a failure to record vital signs at any time and a failure to record the use of supplemental oxygen.
5. Failure to assure that a proper pre-anesthetic evaluation had been performed.
6. Abandonment of the anesthetist's station at the head of the operating table before the patient's emergence from anesthesia.

In addition, the nurse-anesthetist was not properly re-

certified at the time of the procedure and did not attach available electronic monitoring equipment.

The anesthesiologist, hired nine months earlier to upgrade anesthesia care at the clinic, was summoned when the patient was found not to be breathing. On arrival, the anesthesiologist did not detect a pulse, but under his direction a heartbeat was returned. A mobile intensive care unit transported the patient in a deep coma to a hospital emergency department.

Under the state medical licensing law, *NJSA* 45:1-21, SBME may suspend or revoke the license of a physician who has engaged in gross negligence, repeated acts of negligence, professional misconduct, or violations of law or Board-approved regulations, or who lacks the capacity to practice medicine.

In this case, SBME found that the anesthesiologist had failed to supervise the nurse-anesthetist properly and had failed to verify her credentials. These failures, concluded the Board, constituted "repeated acts of negligence" sufficient to warrant a suspension. The period of active suspension was set at two months and fines and costs were levied.

On appeal from the Board, Judges Pressler, Gruccio, and Landau concluded that the physician's "lack of proper supervision during one isolated procedure alone could not be deemed to constitute 'repeated acts of negligence.' " The failure to check the nurse-anesthetist's credentials, added the court, "is merely one of the proofs that suggest" that the physician failed to meet his supervisory obligations.

The court's decision was very limited in its application. The Board, it stated, could have found repeated acts of negligence on the basis of the evidence adduced at the hearing. However, the "repeated acts" cited by the Board were not in fact repeated acts, implied the court, but rather different aspects of the same act: the physician's failure to supervise a particular nurse-anesthetist properly in one case.

The court noted that "negligence," in this context, equates with "malpractice": It is a "deviation from normal standards of conduct."

As a reviewing body, the appeals court could not thoroughly substitute its judgment for the Board's judgment. Rather, the court could only determine whether the Board's findings of fact were adequate to sustain the Board's decision, and whether the findings of fact could have been reached reasonably on the evidence in the record.

The court also observed that "a physician generally must supervise even the most highly trained nurse-anesthetist." This statement reinforces the principle that in New Jersey nurse-anesthetists may not practice independently. In July, the principle was supported further when the state's Health Care Administration Board gave final approval to hospital regulations that require hospitals to credential physicians to supervise nurse-anesthetists.

In July, on remand, SBME reaffirmed its determination to suspend the physician's license. First, the Board attempted to preserve its authority to suspend a physician's license for repeated acts of negligence in the care of a single patient. "We have long accepted the precept," argued the Board, "that discrete and different types of negligent behavior evidenced in the care and treatment of a single patient on one particular day could form the predicate for a finding of repeated negligence."

Second, the Board attempted to protect the license suspension by showing that the anesthesiologist had consistently failed to exercise supervisory responsibility. The Board's July decision was not completely explicit in enumerating acts of negligence, but the last sentence of the nine-page decision stated that the physician's "failure to implement a

mechanism to check on April 11, 1985 (the date of the abortion), and the days and months preceding that date are, in the Board's view, what renders him culpable for repeated acts of negligence."

The decision was signed by the Board's new president, Sanford Lewis, MD. An appeal is expected.

DUTY TO WARN

A psychiatrist had no duty to warn a patient's live-in girlfriend, ruled a Pennsylvania court. The patient killed his companion by strangulation in a shopping mall, apparently believing her to be a Soviet agent.

The Superior Court ruled that only a patient's threat to harm a particular person gives rise to a duty to warn a person of impending harm. The patient, diagnosed by the psychiatrist as having schizophreniform disorder, had not expressed an intent to harm his companion.

PATIENT'S RIGHT TO DIE WITH DIGNITY

A hospital and patient's family have wrangled in a Minnesota court over the hospital's attempt to disconnect the patient's ventilator. The case, involving 86-year-old Helga Wanglie and her family, has attracted national attention.

The court denied the Hennepin County Medical Center's petition to appoint an independent conservator for Mrs. Wanglie. The denial left Mrs. Wanglie's husband with the authority to keep the ventilator in place. Three days after the court spoke, the patient died.

Significant in the Wanglie case is a health care provider's resort to the judicial system to override a family's decision to keep a comatose patient alive by mechanical means. To health care providers, the case raises the specter of contending in court over the ongoing care of a specific patient. To patients, the case raises apprehensions that the very people whom they entrust with their lives may go to extraordinary lengths to let them die.

Many commentators have applauded the judge's decision to keep the decision in the hands of the family. But some commentators, including American Medical Association trustee Nancy Dickey, MD, question the wisdom of allowing patients and families to exercise options that are not viable medically. Dr. Dickey is scheduled to speak October 30, 1991, at the Medical Society of New Jersey headquarters in Lawrenceville as part of a conference on another large ethical issue, HIV testing.

MALPRACTICE POLICY DEVELOPMENTS

Conflicting evidence has appeared regarding trends in the incidence and cost of malpractice claims. The Physician Insurers Association of America (PIAA) reported a cheering 1.8-percent decline in malpractice premiums in 1990, complementing a 19-percent increase in surpluses held by the PIAA's member companies.

However, the St. Paul Fire and Marine Insurance Company, with approximately 30,000 physician insureds in 42 states, experienced a 9.7-percent increase in claims frequency (from 12.4 to 13.6 claims per 100 physicians) during the same year. The increase ended a five-year decline in the incidence of claims.

Moreover, the average cost of claims against St. Paul (other than the relatively few large claims exceeding $200,000) rose 11 percent to $36,400.

The Medical Inter-Insurance Exchange of New Jersey (MIIENJ) climbed from fifth to fourth place among physician insurers in the size of the company surplus, while in gross premiums the New Jersey company went

from sixth to fifth place. MIIENJ continued to rank sixth in the number of insureds, with 7,824 in 1990, according to PIAA data. There were 42 member companies in 1990, and one firm has since withdrawn from membership.

MARKETPLACE COMPETITION

Minneapolis has been viewed as a laboratory for marketplace competition in health care ever since health maintenance organizations (HMOs) attracted large numbers of participating physicians in the Twin Cities in the late 1970s. Indeed, HMOs are seen almost as a Minneapolis invention.

In June, the National Health Policy Forum, affiliated with George Washington University in the nation's capital, released a report indicating that pro-competitive strategies in the Twin Cities have succeeded in "neither limiting hospital resources nor reducing the oversupply of hospitals and hospital services." The report, prepared by respected Washington, DC, health policy analyst Stanley B. Jones, challenged the theory that greater consumer choice in health plans will contain costs.

Physicians are responding to HMO market forces by forming larger groups of practitioners in order to increase bargaining power, according to Mr. Jones. And, many physicians are associating with hospitals in practice management, primary care networks, and continuous quality improvement programs.

In short, ideology may not provide a "magic bullet" for restraining health care costs.

PROFESSIONAL LIABILITY

The Department of Professional Liability Control of the Medical Society of New Jersey developed this commentary. The department is directed by James E. George, MD, JD. Collaborating in the preparation of the commentary is Neil E. Weisfeld, JD, MSHyg. Mr. Weisfeld serves as MSNJ's director of education, research, and regulatory affairs. □

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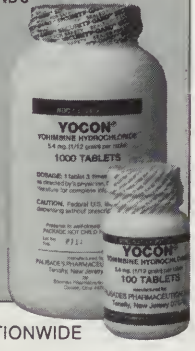
Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

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References:

1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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BOOK REVIEWS

CANCER RISK ASSESSMENT

Samuel C. Morris. New York, NY, Marcel Dekker, Inc., 1990. Risk assessment is a relatively new and, as yet, incompletely defined scientific discipline. Basically, risk assessment represents an attempt to identify hazards and develop ways of modifying them to promote health and safety and minimize the adverse impact on both. Combining biology, chemistry, physics, and engineering with the social sciences, risk assessment takes into consideration toxicology and epidemiology and attempts to deal with risk management in a "holistic" way.

This book, *Cancer Risk Assessment. A Quantitative Approach,* is one of a series of reference works on various aspects of occupational safety and health. It was written by an environmental health scientist with considerable professional experience. He attempts to sort out the complex and confusing array of factors relating to cancer risk and their influence on government and industrial policy.

The material is intended for a wide but well-defined audience: environmental scientists, occupational safety and health professionals, civil engineers, oncologists, epidemiologists, toxicologists, pathologists, molecular biologists, biostatisticians, and government and industry regulatory personnel.

Unfortunately, the book suffers from the attempt to be all-encompassing. Much of the material is abstruse, making it difficult for the reader to get a "handle" on what the author is trying to do. Perhaps the book was too ambitious an undertaking for a field still in search of definition. The text contains a jumble of Casey Stengel-like circumlocutions and the reader is left to grope for the meaning of much of this jargon. ☐ Alan J. Lippman, MD

COMBINED MODALITY CANCER THERAPY

Jacob J. Lokich, MD; John E. Byfield, MD, PhD. Chicago, IL, Precept Press, Inc., 1991. This volume, *Combined Modality Cancer Therapy. Radiation and Infusional Chemotherapy,* is a timely and well-conceived book. The modern approach to cancer treatment recognizes the need for integrating effective therapeutic modalities aimed at local as well as systemic control of the disease. This multidisciplinary approach replaces the outdated stepwise strategy of primary ablative surgery or radiation therapy followed by systemic chemotherapy or palliative radiation therapy in the event of recurrence or metastases. This book reviews data from many years of clinical trials and crystallizes the rationale for the most effective and proved combination of chemotherapy and radiation therapy in the treatment of different sites of cancer.

The book consists of 15 chapters, with a preface and an epilogue. Twenty experts contributed to this volume, spanning 250 pages including the index. The first 2 chapters discuss the experimental and clinical basis for combined radiation and chemotherapy followed by a chapter outlining the principles and practice of infusional chemotherapy. The remaining 12 chapters are individually devoted to the following cancer sites: lung, head and neck, esophagus, liver, bile duct, pancreas, rectum, anus, soft tissues, bladder, gynecological, and brain. Relevant references follow

each chapter. Although the book is authored by contributors from different parts of the country, the chapters are streamlined in format and style, a great achievement for the editors. This book is highly recommended to all clinical oncologists, especially those practitioners who are not yet aware of the virtue of combined modality cancer therapy. □
Ismail Kazem, MD

IMMUNOBIOLOGY OF THE MATERNAL FETAL INTERFACE

WG Thomas; TJ Gill; E Nisbet-Brown. New York, NY, Oxford University Press, 1991. The field of immunology is expanding due to the use of cellular and molecular cloning techniques. Communication links between previously unrecognized portions of the immune system including central nervous system, reproductive organs, and the gastrointestinal tract are being recognized. Mammalian reproduction clearly is influenced by cells and the products of the immune system and is one of the most dynamic areas of research today focusing on maternal-fetal signaling and how fetal survival is compromised or enhanced by these interactions.

This book, *Molecular and Cellular Immunobiology of the Maternal Fetal Interface,* is based on papers presented at the Third Banff Conference on Reproductive Immunology held in January 1989. This is the third book of a series focusing on immunology of reproduction. The first compilation of these topics occurred by the same editors in 1983. The second conference, published in 1987, focused on immunoregulation and fetal survival and explored immunological mechanisms operative in the placenta, the fetus, and the mother. The third conference focused on the molecular and cellular nature of maternal-fetal signaling, to develop the theme of "molecular languages" of the hematopoietic/lymphoid, trophoblast/decidua and endocrine systems in the fetus as well as the mother. The book is broken down into three parts: fetal major histocompatibility complex; decidual effector cells; and cytokines. The compilation by many international authorities found within this text is quite extensive. It is clear that anyone interested in reproductive immunology should review all three publications since the transplantation of fetal tissue remains an unresolved question and may unveil important immunological principles of the immune system as a whole and that will help develop logistical approaches to the transplantation of other tissues. □
Leonard Bielory, MD

A PRACTICAL GUIDE TO ELISA

DM Kemeny. New York, NY, Pergamon Press, 1991. A Practical Guide to ELISA was written by a hard-working, intelligent young man from England. The book clearly lives up to its name as a practical guide for anyone interested in troubleshooting and understanding the mechanics of developing an enzyme-linked immunosorbent assay (ELISA). Basic aspects of the immunoassays and assay designs are discussed clearly with "recipes" given for a variety of medica utilized in these assays. Specific details are given to methods of calibrating equipment and interpreting results. There is even a special chapter on "troubleshooting" that is extremely useful for those neophytes utilizing these extremely powerful and useful serological research techniques. All in all, I can only highly recommend this concise book to any researcher truly interested in initiating a variety of ELISA methods in his area, as it is truly a cookbook written intelligently, legibly, and affordably. □
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I realize that the Medical Society of New Jersey may be legally bound to publish such distasteful advertisements at the expense of its own members. It truly is a blot on trained allergists, physicians, MSNJ, and the patients we serve. ☐ Frank J. Picone, MD

I truly was disappointed to see the message purported in the advertisement for the Allergy TestingCenter® in *NEW JERSEY MEDICINE.*

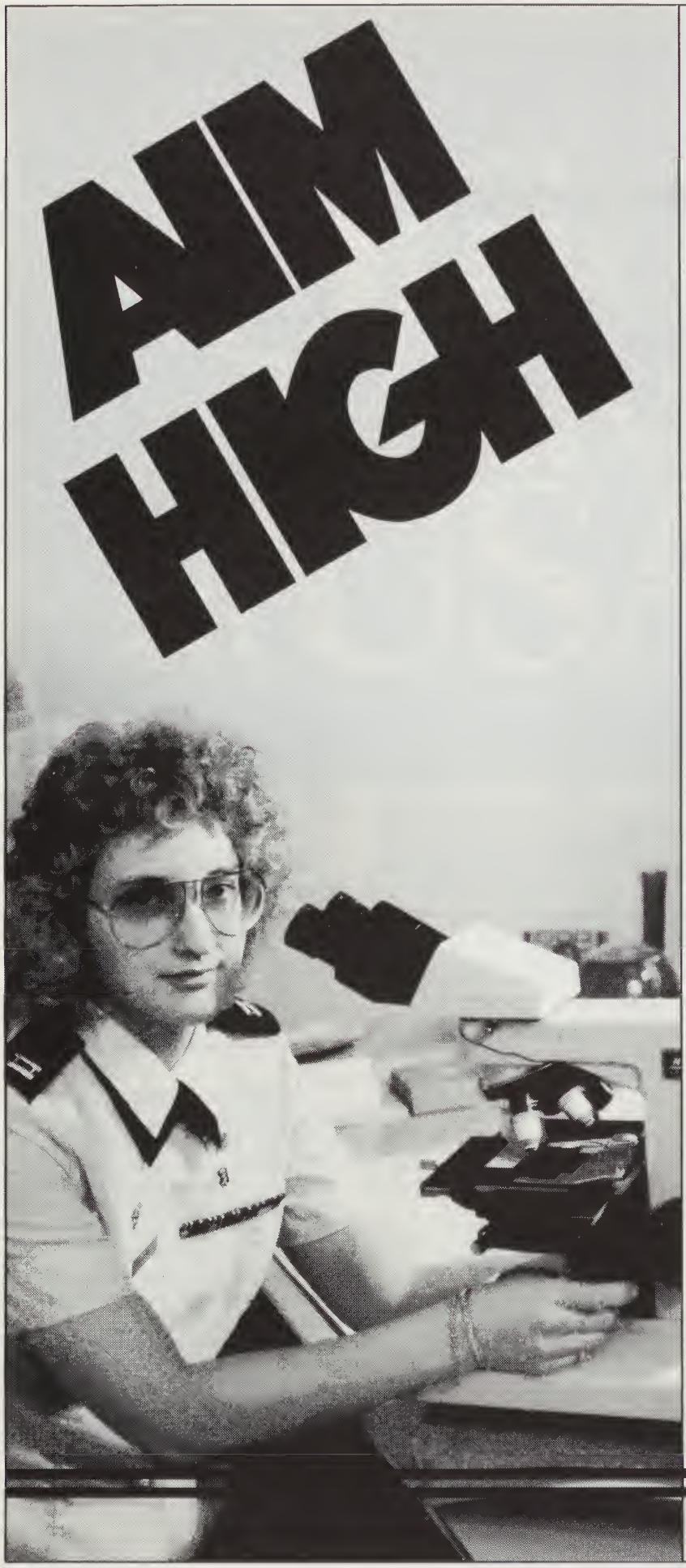
I completely understand that there is no MSNJ endorsement of the services described in this advertisement. The advertisement reads, "We Give You More Than Other Allergists . . . Your Patients Back." This concept is counter to the basic concepts underlying medical care set forth by MSNJ in 1965: "The patient is free to select the physician or physicians whose services he engages."

Many practicing allergists encourage patients to return to the primary care physician and try to work collaboratively because allergists recognize the ability of the primary care physician and the importance of ongoing comprehensive care. Yet, individual patients who insist upon the allergist to render care cannot be turned back for this reason alone.

If, in fact, the contention made here is true and that allergists frequently overtake the care of patients referred by primary care physicians, this reflects the patient's perception that a subspecialist is more capable of rendering a higher level of care. It is unfortunate that some patients who genuinely could benefit from an allergy evaluation never are referred for fear that they may not return. Certainly, the patient's health and welfare should override any other concern or interest.

The message in this advertisement casts allergists in an unfavorable light to their colleagues. As practitioners of medicine, it is the responsibility of MSNJ to equally safeguard our rights in a dignified manner. ☐ Robert M. Klein, MD

Editor's note. Drs. Picone and Klein are correct. MSNJ and the editorial staff do not endorse the services described in the advertisement.



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AIR FORCE

EDITOR'S DESK



ADVERTISING

The status of the physician is not, as some of us may believe, an immutable one. It is not even established, for the most part, by the physician. It is a social phenomenon and changes with alterations in the societal milieu. Government, of course, has a major impact and has throughout the ages. The media increasingly continues to affect our image, usually in a negative way. Bad news sells better than good news; denigration is more salable than praise.

When one combines the activities of government and media, adding the natural tendency of people to lower others to their own level, professionals are deeply in trouble. As Dr. James Todd told members of the American Society of Colon and Rectal Surgeons, "A key focus for the American Medical Association (AMA) is defending physicians' professionalism from the forces that would reduce medicine to a mere trade." Although he was talking about accountability, ethics, and physician payment, and although we agree with him, we prefer to concentrate on marketing.

The AMA has petitioned the Federal Trade Commission (FTC) to allow physician groups to review fee disputes and to adjudicate them. There is no doubt that the perception of the American physician could be markedly enhanced if county societies had the teeth to settle local problems locally. It might require legislative approval rather than FTC regulation, but it is worth trying. At the very least, it might educate and assuage Ann Landers, who constantly complains about the failure of the medical profession to police itself without understanding how impotent we are in this sphere.

But let us concentrate on another activity supervised by the FTC—advertising. Those of us who entered private practice in the days before Titles XVIII and XIX can recall vividly the proscriptions placed on us by our confreres. Cards announcing the opening of an office were limited in size, limited in verbiage, and limited in distribution to colleagues and to newspapers. Newspaper notices also were limited in frequency and could be used only for openings, relocations, and the like. The size and types of signs at office locations also were sharply limited. Physicians never even dreamed of radio and television advertising.

Today, it is almost "the sky's the limit." We expect to see powerful searchlights announcing the opening of an office, dueling blimps, neon signs with arrows pointing to the clinic entrance, daily or weekly blue-plate specials (two hernias for the price of one, a free urinalysis with every electrocardiogram), free chances for dinners or trips, or perhaps free markers for use in Atlantic City casinos. Not all of these ideas are fanciful: some are actually old hat; others are in the works.

The highest court in the land allows, nay mandates, wide discretion in the ability of physicians to advertise. The court and the FTC insist that proper, liberal advertising is better for the public; it will give necessary information and will allow more competitive pricing. But the FTC and the Supreme Court, despite their near-omnipotence, do not have the ability, only the power, to determine what constitutes deceptive advertising. They cannot possibly understand that a true advertisement still may be deceptive and that buzz words, especially those representing the latest in media fashion, can attract the reader the way honey attracts bees and bears. Does sutureless really mean no sutures? Is the laser

really superior to other modalities for all advertised purposes? What is the track record of laparoscopic hernia repair? Can anyone but a physician in the same discipline evaluate the whole truth in advertising?

Some physician advertisers consider the money to be well spent. Yet 70 percent of physicians surveyed by *Medical Economics* spend less than 1 percent of gross income on marketing, only 10 percent felt their marketing efforts had a real impact on volume and more than 50 percent thought their efforts produced little or nothing of benefit.

Some physicians, all reactionaries and fuddy-duddies, of course, feel that the relaxation of advertising rules for the profession has been much more harmful than beneficial. They feel that the patient is not receiving proper information: the so-called competitive aspects produce no measureable benefit, many patients may be receiving unnecessary or nonindicated therapy, and the cost adds needlessly to the escalating amounts spent on health care.

Some of us feel that advertising creates the greatest disservice to our citizens by devaluing members of the most moral and ethical profession into another class of huckster. Does the average patient believe that physician advertising is done as a public service? If not, how can we continue to take pride in ourselves as true professionals, those who exist primarily for public service and only secondarily for monetary gain? How can the patient place the appropriate trust in the one influencing health and well-being? We have many external forces to resist and we have many principles and pragmatic matters to fight for, but the freedom to expand advertising does not seem to be an appropriate part of our agenda. Instead, we should attempt to obtain legislative approval for some measure of self-determination on ethical issues of peer review, including the proper and beneficial ways of informing our patients. Are we physicians or are we marketing specialists? ☐ Howard D. Slobodien, MD

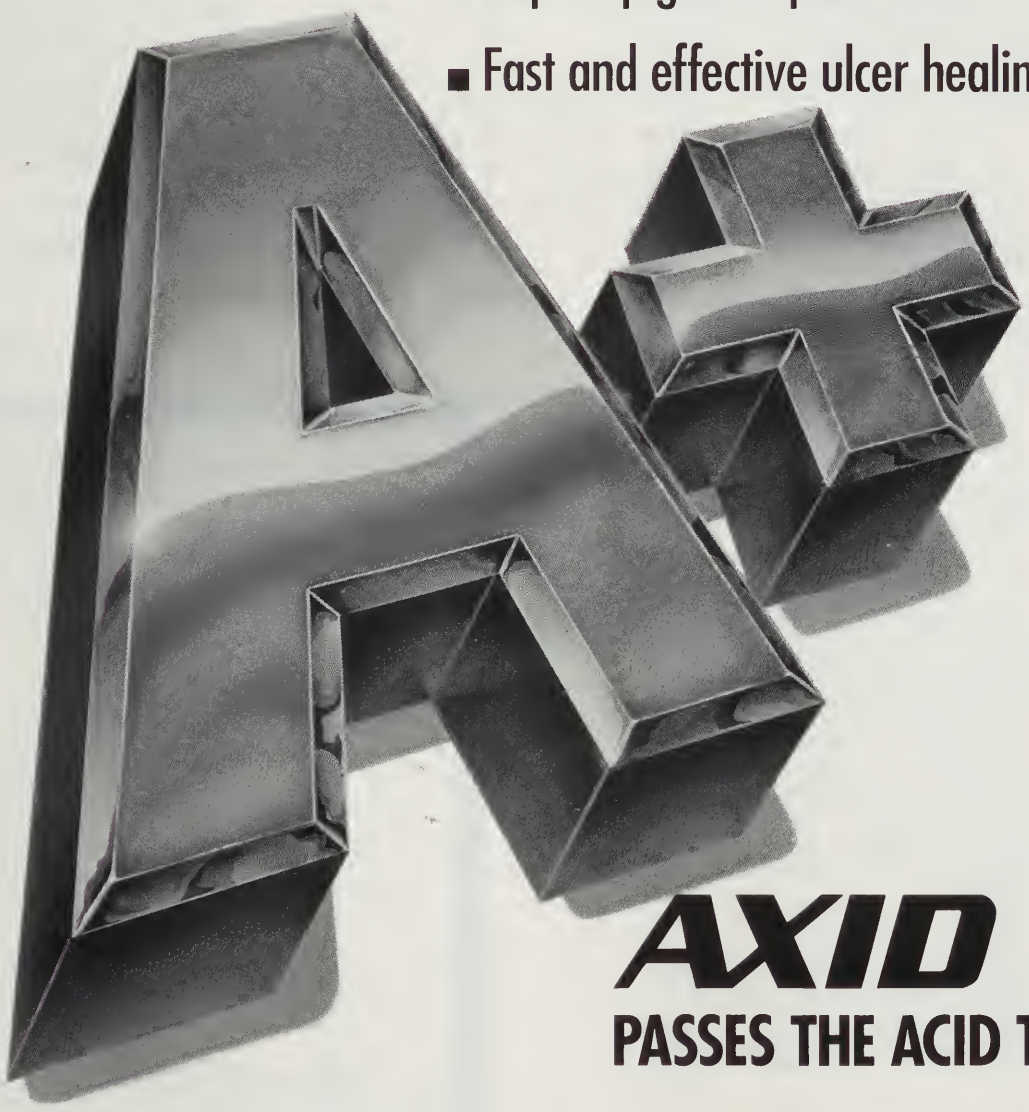
> *Advertisements now are so numerous that they are very negligently perused, and it, therefore, is becoming necessary to gain attention by magnificence of promises, and by eloquences sometimes sublime and sometimes pathetic.* ☐ Samuel Johnson, *The Idler* (1750-1760)

For excellent response in the treatment of duodenal ulcers...

AXID® nizatidine

has the right answers

- Rapid epigastric pain relief[1,2*]
- Fast and effective ulcer healing[2,3,4]



AXID
PASSES THE ACID TEST

*Most patients experience pain relief with the first dose.

See adjacent page for references and brief summary of prescribing information.

NZ-2943-B-149347

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AXID® (nizatidine capsules)

Brief Summary. Consult the package insert for complete prescribing information.
Indications and Usage: 1. *Active duodenal ulcer* – for up to 8 weeks of treatment. Most patients heal within 4 weeks.

2. *Maintenance therapy* – for healed duodenal ulcer patients at a reduced dosage of 150 mg h.s. The consequences of therapy with Axid for longer than 1 year are not known.

Contraindications: Known hypersensitivity to the drug. Because cross sensitivity in this class of compounds has been observed, H_2-receptor antagonists, including Axid, should not be administered to patients with a history of hypersensitivity to other H_2-receptor antagonists.

Precautions: *General* – 1. Symptomatic response to nizatidine therapy does not preclude the presence of gastric malignancy.

2. Dosage should be reduced in patients with moderate to severe renal insufficiency.

3. In patients with normal renal function and uncomplicated hepatic dysfunction, the disposition of nizatidine is similar to that in normal subjects.

Laboratory Tests – False-positive tests for urobilinogen with Multistix® may occur during therapy.

Drug Interactions – No interactions have been observed with theophylline, chlordiazepoxide, lorazepam, lidocaine, phenytoin, and warfarin. Axid does not inhibit the cytochrome P-450 enzyme system; therefore, drug interactions mediated by inhibition of hepatic metabolism are not expected to occur. In patients given very high doses (3,900 mg) of aspirin daily, increased serum salicylate levels were seen when nizatidine, 150 mg b.i.d., was administered concurrently.

Carcinogenesis, Mutagenesis, Impairment of Fertility – A 2-year oral carcinogenicity study in rats with doses as high as 500 mg/kg/day (about 80 times the recommended daily therapeutic dose) showed no evidence of a carcinogenic effect. There was a dose-related increase in the density of enterochromaffin-like (ECL) cells in the gastric oxyntic mucosa. In a 2-year study in mice, there was no evidence of a carcinogenic effect in male mice, although hyperplastic nodules of the liver were increased in the high-dose males as compared with placebo. Female mice given the high dose of Axid (2,000 mg/kg/day, about 330 times the human dose) showed marginally statistically significant increases in hepatic carcinoma and hepatic nodular hyperplasia with no numerical increase seen in any of the other dose groups. The rate of hepatic carcinoma in the high-dose animals was within the historical control limits seen for the strain of mice used. The female mice were given a dose larger than the maximum tolerated dose, as indicated by excessive (30%) weight decrement as compared with concurrent controls and evidence of mild liver injury (transaminase elevations). The occurrence of a marginal finding at high dose only in animals given an excessive and somewhat hepatotoxic dose, with no evidence of a carcinogenic effect in rats, male mice, and female mice (given up to 360 mg/kg/day, about 60 times the human dose), and a negative mutagenicity battery are not considered evidence of a carcinogenic potential for Axid.

Axid was not mutagenic in a battery of tests performed to evaluate its potential genetic toxicity, including bacterial mutation tests, unscheduled DNA synthesis, sister chromatid exchange, mouse lymphoma assay, chromosome aberration tests, and a micronucleus test.

In a 2-generation, perinatal and postnatal fertility study in rats, doses of nizatidine up to 650 mg/kg/day produced no adverse effects on the reproductive performance of parental animals or their progeny.

Pregnancy – Teratogenic Effects – Pregnancy Category C – Oral reproduction studies in rats at doses up to 300 times the human dose and in Dutch Belted rabbits at doses up to 55 times the human dose revealed no evidence of impaired fertility or teratogenic effect; but, at a dose equivalent to 300 times the human dose, treated rabbits had abortions, decreased number of live fetuses, and depressed fetal weights. On intravenous administration to pregnant New Zealand White rabbits, nizatidine at 20 mg/kg produced cardiac enlargement, coarctation of the aortic arch, and cutaneous edema in 1 fetus, and at 50 mg/kg, it produced ventricular anomaly, distended abdomen, spina bifida, hydrocephaly, and enlarged heart in 1 fetus. There are, however, no adequate and well-controlled studies in pregnant women. It is also not known whether nizatidine can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Nizatidine should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers – Studies in lactating women have shown that 0.1% of an oral dose is secreted in human milk in proportion to plasma concentrations. Because of growth depression in pups reared by treated lactating rats, a decision should be made whether to discontinue nursing or the drug, taking into account the importance of the drug to the mother.

Pediatric Use – Safety and effectiveness in children have not been established.

Use in Elderly Patients – Healing rates in elderly patients were similar to those in younger age groups as were the rates of adverse events and laboratory test abnormalities. Age alone may not be an important factor in the disposition of nizatidine. Elderly patients may have reduced renal function.

Adverse Reactions: Clinical trials of varying durations included almost 5,000 patients. Among the more common adverse events in domestic placebo-controlled trials of over 1,900 nizatidine patients and over 1,300 on placebo, sweating (1% vs 0.2%), urticaria (0.5% vs <0.01%), and somnolence (2.4% vs 1.3%) were significantly more common with nizatidine. It was not possible to determine whether a variety of less common events were due to the drug.

Hepatic – Hepatocellular injury (elevated liver enzyme tests or alkaline phosphatase) possibly or probably related to nizatidine occurred in some patients. In some cases, there was marked elevation (>500 IU/L) in SGOT or SGPT and, in a single instance, SGPT was >2,000 IU/L. The incidence of elevated liver enzymes overall and elevations of up to 3 times the upper limit of normal, however, did not significantly differ from that in placebo patients. All abnormalities were reversible after discontinuation of Axid. Since market introduction, hepatitis and jaundice have been reported. Rare cases of cholestatic or mixed hepatocellular and cholestatic injury with jaundice have been reported with reversal of the abnormalities after discontinuation of Axid.

Cardiovascular – In clinical pharmacology studies, short episodes of asymptomatic ventricular tachycardia occurred in 2 individuals administered Axid and in 3 untreated subjects.

CNS – Rare cases of reversible mental confusion have been reported.

Endocrine – Clinical pharmacology studies and controlled clinical trials showed no evidence of antiandrogenic activity due to nizatidine. Impotence and decreased libido were reported with equal frequency by patients on nizatidine and those on placebo. Gynecomastia has been reported rarely.

Hematologic – Fatal thrombocytopenia was reported in a patient treated with nizatidine and another H_2-receptor antagonist. This patient had previously experienced thrombocytopenia while taking other drugs. Rare cases of thrombocytopenic purpura have been reported.

Integumental – Sweating and urticaria were reported significantly more frequently in nizatidine- than in placebo-treated patients. Rash and exfoliative dermatitis were also reported.

Hypersensitivity – As with other H_2-receptor antagonists, rare cases of anaphylaxis following nizatidine administration have been reported. Rare episodes of hypersensitivity reactions (eg, bronchospasm, laryngeal edema, rash, and eosinophilia) have been reported.

Other – Hyperuricemia unassociated with gout or nephrolithiasis was reported. Eosinophilia, fever, and nausea related to nizatidine have been reported.

Overdosage: Overdoses of Axid have been reported rarely. If overdosage occurs, activated charcoal, emesis, or lavage should be considered along with clinical monitoring and supportive therapy. Renal dialysis does not substantially increase clearance of nizatidine due to its large volume of distribution.

PV 2091 AMP
[091190]

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1. Data on file, Lilly Research Laboratories.
2. *Scand J Gastroenterol.* 1987;22(suppl 136):61-70.
3. *Scand J Gastroenterol.* 1987;22(suppl 136):47-55.
4. *Am J Gastroenterol.* 1989;84:769-774.

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Additional information available to the profession on request.

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PRESIDENT 'S PAGE

ACTIVATING INTERNATIONAL MEDICAL GRADUATES

There still remains evidence of discriminatory practices in the licensure, postgraduate training, hiring, and credentialing of international medical graduates (IMGs). Such behavior is unworthy of a democracy, and of our honored profession. To suppress this lingering embarrassment to medicine in the U.S., bold steps are being taken to end such separate and unequal treatment.

A. *What is the American Medical Association (AMA) doing for IMGs?*

The AMA has changed its focus regarding IMGs in the past few years, especially since Doctor James Todd has become executive vice-president. Before moving to Chicago, Doctor Todd lived and practiced in New Jersey. His policy of demonstrating equality for IMGs is reflected in several recent AMA actions:

1. Strong support for federal regulation to end discrimination against IMGs who are applying for state licensure, or who are applying for reciprocity when moving from one state to another.

2. End to any covert "quotas" on IMGs applying for resident programs. There has been a misperception that hospitals would receive lower Medicare reimbursement rates if they hired large numbers of IMGs.

3. Seek to implement a National Accreditational Verification Service, already accepted by ten State Boards, that would work as a national clearinghouse, collecting physicians' credentials and producing this information on request to licensing Boards.

Also, in June 1991, the House of Delegates of the AMA passed Resolution #217, encouraging county and state medical societies to identify qualified and interested IMGs to be invited, appointed, and elected to committees and leadership positions within the house of medicine. After all requirements have been met for medical education, training, and licensure, a physician is a physician is a physician.

However, one sad fact remains—of the 435 members of the AMA's House of Delegates, only 9 are IMGs, 3 of whom are from New Jersey! Palma Formica, MD, is the first IMG on the AMA's Board of Trustees since its inception. It is obvious that we need more activity and a stronger voice in organized medicine for the IMG community.

B. *What are we doing in New Jersey?*

1. It is time to pull together to show all IMGs that we care about them, we need their input, and we want them to become involved and active in organized medicine.

2. There are 27,557 physicians licensed in the state of New Jersey, of whom approximately 17,000 physicians practice in the state. Of the latter number, 8,643 physicians are IMGs. However, only 2,213 physicians (26 percent) belong to the Medical Society of New Jersey (MSNJ), while 6,430 physicians do not belong to MSNJ. It is unfortunate that all this talent is being wasted.

3. IMGs in New Jersey do not have to take a back seat to anyone. There are several past-presidents of MSNJ, many county society presidents, and presently seven members of the Board of Trustees who are IMGs.

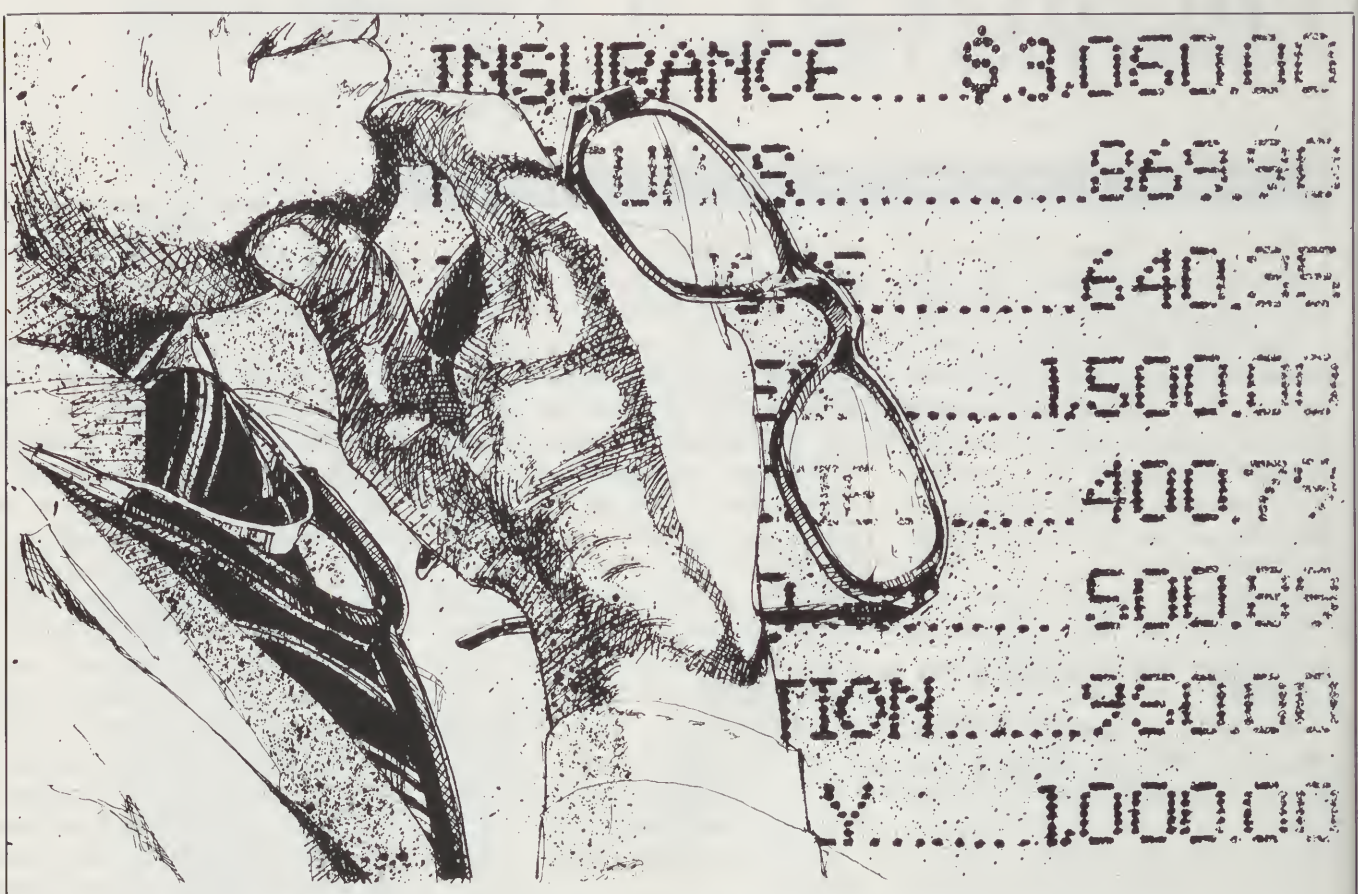
4. Three years ago at the AMA meeting in Chicago I represented New Jersey. I proudly testified before a reference committee in favor of having only one licensing examination for both IMGs and United States Medical Graduates (USMGs). Those resolutions evidently passed in the AMA and, along with strong efforts by IMGs, federal legislation has been passed stating that by 1995 there will be only one licensing examination for all physicians.

5. Presently in New Jersey, we are having regular meetings with IMGs. We have developed a plan of action: Through county societies, we plan to have IMGs who belong to MSNJ contact every IMG who does not belong to our Society. We plan one-on-one contact, asking all IMGs to become involved in organized medicine.

Health care professionals now are under siege by entrepreneurs, consumer groups, and the heavy hand of the federal and state governments. How we respond to these pressures may well determine our collective future. With such important issues as AIDS regulations, severe reduction in Medicare reimbursement, and the never-ending professional liability crisis, there never has been a greater need for unity or a greater need to belong to organized medicine.

There are many separate IMG organizations. But, all of the ideas and proposals generated through these separate organizations will not have much effect if they are isolated from the activities and actions of MSNJ and the AMA.

As IMGs and USMGs, we practice together, we socialize together, and we live side by side in our great country. We need to collaborate to strengthen our health care system and protect the interests of all patients and of all physicians. Together we can! Together we must! We are family. God bless. ☐ Joseph A. Riggs, MD



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The Study of Cancer in Minorities

Dona Schneider, PhD, MPH
Michael R. Greenberg, PhD
Daniel Wartenberg, PhD
Howard Kipen, MD, MPH

Data inventories provide a concise reference base for researchers. The authors created a set of reference volumes listing databases used for studying cancer in New Jersey minorities. The process followed can be adapted for other disease outcomes or other regions.

Striking differences between the health status of black, other minority, and white populations of the United States were noted by Secretary of Health and Human Services Margaret M. Heckler in 1984.[1] The more than five-year difference in life expectancy between blacks and whites, the wide disparity in infant mortality, and the increased burden of disease and disability among minorities caused the Secretary to call for a special task force to develop a coordinated strategy to investigate and improve the health status of all minority groups. The task force found 80 percent of the excess mortality among minorities in six areas: cancer; cerebrovascular and cardiovascular disease; chemical dependency; diabetes; homicide, suicide, and injuries; and infant mortality.[2]

In response to the task force findings, the Advisory Committee on Cancer Prevention and Control of the New Jersey Commission on Cancer Research made cancer among blacks, Hispanics, and the economically disadvantaged its number one priority in 1987. To determine the feasibility of studying cancer rates among these targeted populations in New Jersey, the authors conducted an evaluation of the quantity and quality of data already available for this purpose. The goals of this inventory and review of available data sets were: to preclude designing studies that had been done; to provide a listing of available databases for other researchers; and to point out pitfalls of existing data sets. The authors believe the process followed can be adapted for other states and/or regions, and for other disease outcomes. The purpose of this paper is to describe the process followed and to report the results found in identifying and reviewing data sets useful for the study of cancer among minorities in New Jersey.

METHODS

Demographic, health, environmental, employment, and behavioral information were selected as data sources for the study of minority cancer (Figure).

The authors began by defining the major categories of sources of data sets: federal, state, local, and proprietary (corporate and union). Preliminary telephone discussions indicated that military sources would not be cooperative, and these were excluded.

Federal and State Government Data Sets. Library materials such as the *Inventory of U.S. Health Care Databases, 1976-1987* (DHHS HRS-P-OD 88-2), government reports and monographs such as *SEER: Incidence and Mortality Data, 1973-1977* (NCI monograph 57), pamphlets, and telephone directories of governmental agencies were obtained and reviewed. Many pamphlets and telephone directories have organizational charts, allowing identification of individuals in charge of research divisions or departments. Two examples are the National Center for Health Statistics introductory pamphlet (PHS 83-1200) and the telephone directory of the New Jersey State Department of Environmental Protection. We used these types of references to determine departmental directors and commissioners at both the state and federal levels.

Identified officials were contacted by telephone to discuss what data sets were maintained by an individual division or department, and to ask about other data sets that might be available. Top level officials provided names and telephone numbers of those in charge of specific data sets, or identified persons to contact to obtain this information.

We designed a data collection instrument for interviewing data managers in person and by telephone. The instrument was pretested on state and local health department officials. Once a data

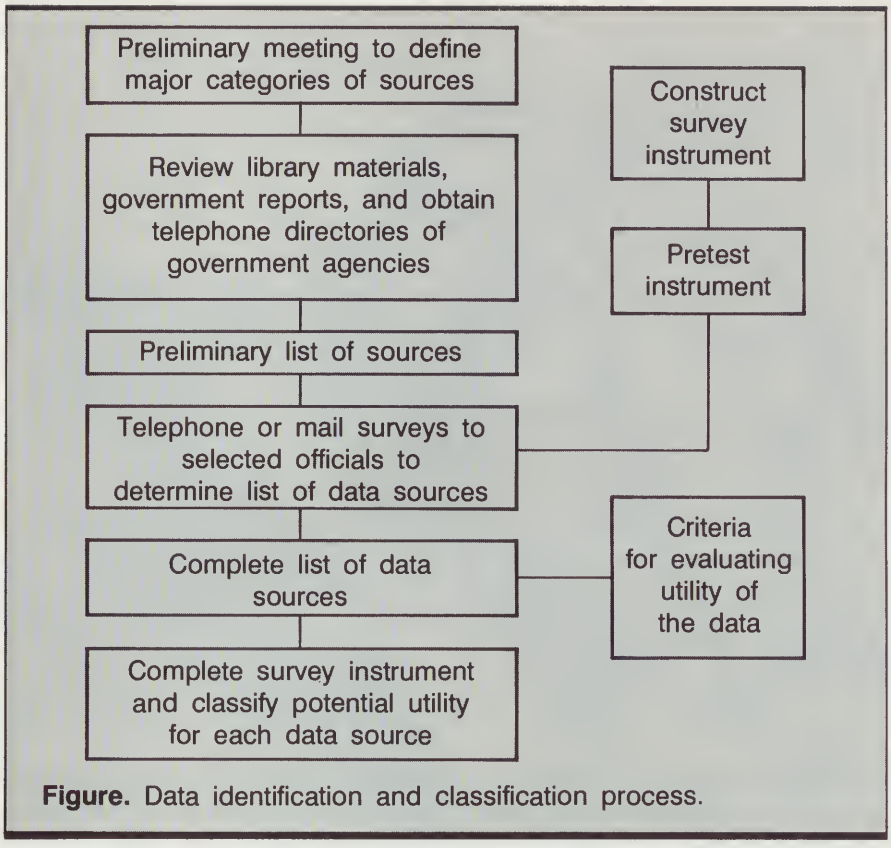


Figure. Data identification and classification process.

set was identified, the official responsible for maintaining the data set was contacted and interviewed. The survey instrument covered 16 variables. We list each and illustrate with an example:

1. Data set name (AIDS Registry).

2. Data description. (These data represent all reported cases of AIDS in New Jersey since the first recorded case in 1981. The Registry began in 1984 and reporting was voluntary until October 1986. The data are not maintained by year, but represent a dynamic database.)

3. Agency responsible for the data set (New Jersey State Department of Health, AIDS Registry).

4. Name, address, and telephone number of the person to contact to obtain information about or to access the data set (current official at 609/984-5940).

5. Time coverage of the data set (1984 to present).

6. How often the data are updated. (New cases are being added continually with updates on each registrant every three months.)

7. Whether the data are collected in an ongoing fashion or represent a special or delineated study (ongoing program).

8. Whether the data are available in hardcopy or automated format (microcomputer database with CDC software).

9. Number of subjects covered in the data set (4,764 subjects as of July 31, 1988).

10. Number of minority subjects, especially blacks and Hispanics (52 percent of the cases are black and 13 percent of the cases are Hispanic).

11. Data set variables (personal identifiers, date of birth, age at diagnosis, date of death if appropriate, gender, race, ethnicity, country of birth, residence at time of onset of illness with AIDS, hospital that established diagnosis, social and risk factors, extensive diagnosis of AIDS-related illnesses, laboratory data, name of physician diagnosing AIDS).

12. Whether or not health outcome is reported. (Health outcome, such as diagnosis of Kaposi's sarcoma, is updated on each registrant every three months by the surveillance staff of DOH, including death information where relevant.)

13. Uniformity of coding. (Coding has been done uniformly via Centers for Disease Control (CDC) guidelines using CDC software since the Registry began.)

14. Selection of subjects and controls (all reported cases, no controls).

15. Limitations of the data, including costs if the data must be purchased. (This is a sensitive database and access must be obtained through New Jersey State Department of Heath Internal Review Board.)

16. Commentary from the interviewer on the utility of the data for the study of cancer among minorities. (The AIDS Registry is slated to be tied into New Jersey Vital Statistics and the Cancer Registry within the next two years.)

Items #13 through #16 are qualitative, yet the authors sought the information because it provided insight into constraints and possibilities that researchers might not be aware of when using these data sets. Uniformity of coding (Item #13), for instance, is a particularly difficult issue for epidemiologists. ICD codes change, racial coding changes, and variables are added and dropped from some data sets for specific years. If coding problems are understood before the analysis of a data set is attempted, a research design can assign adequate time and resources to the problem. Alternatively, a researcher may choose to avoid a data set that will require too much time and/or resources to analyze.

Understanding why a database was collected and the logic behind the selection of subjects and controls (Item #14) can help researchers understand possible biases in the data. Those responsible for data sets discussed selection of subjects and controls, and provided protocols whenever possible. Protocols especially were useful for identifying geo-

graphic coverage of subjects and controls, and indicated potential problems with selection bias. For example, if random digit dialing was part of the protocol, only those with telephones were part of the database.

Data managers were asked what they felt were limitations of the data set (Item #15), and whether they felt that given databases were useful for the study of cancer among minorities (Item #16). These questions were asked to cover data problems, biases, and data possibilities that might not have been directly addressed. The authors did not know, for example, that plans were underway to link the AIDS Registry with the Cancer Registry within a few years. This information can only be obtained if open-ended questions soliciting opinion about the data set are part of the interview process.

Local Health Departments. Local health agencies are potential sources of data. There are 115 local health departments in New Jersey. Preliminary research indicated that health departments would have the same data as federal and state agencies, yet it was possible that health departments might have additional data sets. Furthermore, health departments are strategically placed for assisting state and federal researchers in gathering and integrating data. Thus, local and regional health departments with the most black and Hispanic residents were surveyed.

In the 11 New Jersey counties that contained 85 percent of the target populations (blacks and Hispanics) for the period 1960 to 1980, 41 municipalities with more than 1,000 minority persons were identified. The list of 41 municipalities and a published directory of full-time health officers in New Jersey were compared.[3] The health officers of these municipal and county health departments represented 68 percent of blacks and 65 percent of the Hispanics in New Jersey in 1980.

The authors contacted 41 health departments and asked about possible data sets; all leads with the same survey instrument used for gathering information on state and federal agency data sets were followed up. The authors also asked three additional questions: 1. What are the major health issues in your community? 2. If the state put together a database on black and Hispanic cancer for your community, how useful would it be? 3. Would you be willing to followup specific cancer cases for history of exposure, occupation, and lifestyle factors?

These questions were added to determine whether cancer among minorities was considered a major problem at the local level where other health and socioeconomic problems might compete for attention. The authors also wanted to determine if local health officers might be a source of additional information for obtaining cancer data, that is, whether ongoing state databases might be augmented by local health department input.

Proprietary Databases.

The Corporate Sector. A less aggressive survey strategy was followed for inquiring about proprietary data sets. Because researchers have found corporations increasingly unwilling to release information unless required by law,[4] we felt telephone contacts might be too forward and quickly reach a dead end. Instead, we redefined our goals for proprietary data sets. The authors wished to know if data sets were being collected (employment, health, or other types of records), the size and scope of the workforce/sample, and whether the organizations were willing to work with researchers outside their organization.

For the corporate sector, the authors sent an entry level questionnaire to the chief executive officer (CEO) of the 100 largest employers in New Jersey, and to 24 corporations based outside the state, but with instate facilities;[5] the letters requested the total number of persons employed at the corporation's New Jersey location(s) and for an estimate of the number of black and Hispanic employees. The questionnaire also asked for the type of records maintained on current and previous employees, e.g. accident, health, mortality, work exposures, and the name of a person to contact to discuss these records. Nonrespondents were contacted by telephone after six weeks in an attempt to obtain the initial ques-

Table 1. ***Scoring system for database utility.***

Data Availability	Hardcopy	0
	Automated	1
Time Coverage	No date	0
	<1 year	1
	1-5 years	2
	>5 years	3
Type of Study	Special project	0
	Ongoing project	1
Number of Black or Hispanic Subjects	None or unknown number	0
	<100	1
	100 or more	2
Variables		
Age, Sex, Race	None	0
Ethnicity	Age, sex only	1
Residence	Age, sex, race/ethnicity	2
Exposure	More	3
Health Outcome		

Table 2. *Sources of data for the study of cancer in minorities.*

State and State-Sponsored Data Sets	
Department of Health	27
Department of Environmental Protection	15
Department of Transportation	1
Department of Human Services	2
Department of Labor	65
University of Medicine and Dentistry (UMDNJ)	2
Commission on Agent Orange	1
Total	113
Federal Data Sets	
Department of Commerce	
Bureau of the Census	3
Environmental Protection Agency	1
Nuclear Regulatory Commission	1
Health and Human Services	
Centers for Disease Control (CDC)	1
National Institute for Occupational Safety and Health (NIOSH)	1
National Cancer Institute (NCI)	2
National Center for Health Statistics (NCHS)	13
Total	22

tionnaire data on types of records maintained, the number of workers/subjects, and the person to contact. When secondary corporate contacts were identified by the CEO, second and third mailings were sent with a cover letter indicating the CEO suggested the contact provide further information for our data inventory. The letters asked for information on the types of records, time coverage, number of employees/subjects, and the variables collected. Telephone calls were made four weeks after the mailing to clarify vague and negative responses, and to solicit information from nonrespondents to the second mailing.

In general, contacting corporate sources was more difficult than contacting governmental sources. When corporate sources were contacted, most showed resistance to providing information on even the types of information collected. Many refused to acknowledge they kept any type of employee information, including payroll records. The fear of litigation was the reason most cited for noncooperation.

Union and Other Private Sources. Eight unions with large memberships that had participated in epidemiologic work in the past were selected. Letters and multiple telephone calls yielded some information on the unions, but no unions would comply with our specific request for information on possible databases.

There were private health and research organizations within the state that the authors felt might maintain data sets for their own purposes. The authors generated a list of possible contacts through a roundtable discussion of cancer researchers and a review of telephone directory *Yellow Pages.* These organizations were contacted by telephone and asked about possible data sets; only one organization claimed to be gathering data and would discuss databases with us—the American Cancer Society.

Scoring Data Sets. There is no accepted way of comparing this wide variety of data sets. After examining over 100 data sets, a utility scoring system (Table 1) was needed; it included: availability (hardcopy or automated); time coverage (no date means the time frame is lost or was not collected); type of study (special project such as a one-time migrant worker health survey, or ongoing data collection such as a cancer registry); the number of minority subjects; and whether the data set includes key variables such as: age, gender, race/ethnicity (white, black, Hispanic, other), place of residence (street address, municipality, county), exposure, and health outcome.

An automated database has more utility to researchers than one available only in hardcopy. The authors scored hardcopy as 0 and automated databases as 1, reflecting this difference. We scored data sets higher if they covered longer time periods, were ongoing (data are continually added and updated), had 100 or more minority subjects, and collected information on the key variables.

Two key variables in Table 1 require further explanation: race/ethnicity and place of residence. Although the authors were seeking data sets that could be used for studying cancer in minorities in New Jersey, the lack of one or both of these variables would not preclude its listing in the data inventory. In some cases, it did not even cause the data set to have a low score. For example, a given data set might include housing costs or employment figures on a neighborhood but have no racial/ethnic identifiers. The data set still may have utility to researchers studying minority

Table 3. *State and federal data sets with a utility score of 9 to 10 with agency source.*

Score of 10

1. Cancer Registry Analytic File
   (New Jersey State Department of Health and SEER Registry)
2. Medicaid Eligibility Files
   (New Jersey State Department of Human Services)
3. Medicaid Claim Files
   (New Jersey State Department of Human Services)
4. Mortality Files
   (New Jersey State Department of Health and NCHS)
5. Patient Medical Discharge Abstracts
   (New Jersey State Department of Health)
6. Uniform Billing—82/MIDS generated through hospital billing
   (New Jersey State Department of Health/Blue Cross)

Score of 9

1. Adverse Effects on Birth Outcome
   (New Jersey State Department of Health)
2. AIDS Registry
   (New Jersey State Department of Health)
3. Alcohol, Narcotic, and Drug Abuse Admission/Discharge Reports
   (New Jersey State Department of Health)
4. Confidential Venereal Disease Reports
   (New Jersey State Department of Health)
5. Employee Medical History
   (New Jersey State Department of Transportation)
6. Occupational and Environmental Diseases and Poisonings Registry
   (New Jersey State Department of Health)
7. Population Tapes (multiple)
   (U.S. Bureau of the Census)
8. Register of Silicosis
   (New Jersey State Department of Health)
9. Special Child Health Services Birth Defects Registry
   (New Jersey State Department of Health)

cancer because that data set might be able to be linked to other data sets where the racial information is available. Additionally, behavioral data from a national sample of minorities might provide clues to health outcomes in New Jersey minorities. All environmental, behavioral, demographic, employment, and health databases identified were included in the inventory if they had any possible use for the study of cancer in minorities, even if racial/ethnic and residence data were not available.

The scoring system in Table 1 was listed in our data inventory as a key for researchers to use to define data set features. The highest score a data set could achieve was a 10, indicating it has the most utility for New Jersey researchers studying cancer in minorities. The lowest score is a 0, indicating the data set has serious limitations. The full listing of data sets and their data scores have been reported elsewhere.[5]

RESULTS

Identification of Data Sets. The authors compiled a list of 135 state and state-sponsored, and federal data sets (Table 2). The authors also describe proprietary and local health department results.

a. State and State-Sponsored Data Sets. One hundred thirteen data sets and statistical reports were identified at the state and state-sponsored level. Twenty-seven of these were held by the New Jersey State Department of Health, 15 data sets were held by the New Jersey State Department of Environmental Protection, and 6 data sets were held by other state departments. An additional 65 statistical reports were identified at the New Jersey State Department of Labor. Most of the state and state-sponsored data sets did not score highly on the utility key. Many data sets were available in hardcopy only; some were stored in basement files for many years. Most data sets did not include the key variables of race/ethnicity or health outcome, but a few data sets could be linked to others that did include those variables.

Fourteen state data sets were identified that scored 9 or above on our scoring system. Six data sets scored a 10 on our index and fulfilled all the requirements of automated format, long time frame, more than 100 minority subjects, and contained key variables (age, gender, race, place of residence, and outcome). Eight additional state and state-sponsored data sets scored 9 on the utility scale. Seven of these data sets were held by the New Jersey State Department of Health and 1 data set was maintained by the New Jersey State Department of Transportation. Space precludes listing all the data sets scored. State and federal data sets with a score of 9 or more on the utility scale are listed in

Table 3 along with their sources.

b. Federal Data Sets. At the federal level, the authors identified 22 data sets that could be used for the study of cancer among black, Hispanic, and economically disadvantaged persons in New Jersey. Three data sets were located through the Bureau of the Census, 1 data set was located through the Environmental Protection Agency (EPA), 1 data set was located through Centers for Disease Control (CDC), 1 data set was located through the National Institute for Occupational Safety and Health (NIOSH), 2 data sets were located through the National Cancer Institute, 1 data set was located through the Nuclear Regulatory Commission, and 13 data sets were located through the National Center for Health Statistics (NCHS).

Most of the databases identified currently are available as public use tapes and contain information that may be of use to researchers studying cancer among minority populations in other states/regions as well. These tapes run from $200 to $2,000 per tape and some researchers may find that studies with long time frames or large geographic coverage might be too costly for their budgets.

Some public use tapes scored a 10 on our utility key, e.g. NCHS mortality files, Surveillance Epidemiology and End Results (SEER), but many others do not have health outcome or the geographic definition necessary to identify New Jersey minorities in particular. It should be noted that this need not be a problem for some types of minority cancer research. Investigators working at the national scale, or on behavioral risks might not require outcome or place of residence in their data set. They might be able to utilize data sets that did not achieve a 9 or 10 on our utility scale, e.g., National Health and Nutrition Survey (NHANES), Hispanic Health and Nutrition Survey (HHANES). Still other public use tapes do not have outcome data, but scored highly on our utility scale. Bureau of Census tapes, for instance, scored a 9 and are particularly useful for denominator data.

c. Proprietary Sources. The proprietary data set effort yielded no information from unions, 2 databases from the American Cancer Society, and 27 data sets from New Jersey corporations. All of the corporate databases identify cohorts for potential studies and 3 databases had exposure and outcome data on employees. Two of the 27 corporate sources indicated a willingness to participate in future research projects. One of these sources had records on more than 500 Hispanics and 2,000 blacks in its employ across the United States, including yearly physicals and death certificates. The second corporation had records on 2,000 Hispanics and 5,000 blacks in its employ across the United States, including cohort exposures, medical records, and vital status.

d. Local Health Departments. Local health departments yielded data sets that were available at the state level. In response to our questionnaire, we learned that health problems among minorities vary by both population size and location. Only five of the health departments contacted listed cancer among their major health problems; none of the health departments listed cancer as their primary problem. All of these communities were big cities, and cancer usually fell behind AIDS, drug abuse, sexually transmitted diseases, and hypertension in importance.

All health officers interviewed felt that a database on black and Hispanic cancer for their communities would be useful. They felt it would allow them to make specific statements about rates, answer questions from the community, and help with cancer prevention programs by allowing them to target specific groups in need. All respondents felt local health departments would be the logical level of government to followup identified cancer cases, but that this would require additional dedicated resources.

Recommendations to Researchers. Researchers need to become familiar with their own and the data source's resource limitations before formally requesting data. For example, one database was difficult to obtain because of state personnel changes, changes in bureaucratic procedures secondary to personnel changes, and state budget cuts. The cost for a specific data tape increased more than 100 percent from the time of the original request to the time the tape was obtained.

Secondly, researchers need to focus on a study design that takes into account the limitations of a particular data set. They should also allow sufficient time for processing data requests. It took more than nine months, two departmental meetings, and three internal review board meetings to obtain one particular database.

In addition, researchers interested in minority cancer need to be careful about geographical comparisons, as many data sets lack geographic definition. While linkages between data sets might be possible for correcting this problem, they might not be easily accomplished and may require significant resources. The authors were assured by those responsible for data sets, for instance, that two specific databases could be linked; a year later, these sources acknowledged that they never had linked the two databases.

DISCUSSION

The inventory of databases for use in the study of cancer among blacks, Hispanics, and the economically disadvantaged in New Jersey led to the production of a reference set identifying more than 135 sources of data that can be used by researchers for studying minority cancer. The three-volume set was published and distributed by the New Jersey Commission on Cancer Research to the New Jersey State

Library and all New Jersey college libraries. Some of the databases listed are useful only for denominator data or the identification of cohorts. Still others provide behavioral data, employment data, and/or health outcome data. In all, more data sets were identified than expected.

While the inventory had a very specific audience—New Jersey cancer researchers—the process used to find and categorize data sets can be utilized to create inventories for other health outcomes, or for other states or regions. Indeed, the types of data, e.g. health registries, vital statistics, proprietary records, available in New Jersey can be found in many states, and a centralized listing of these databases can help researchers find lesser known data sets, determine limitations in the data, and improve research designs.

The utility key provided for comparing data sets makes this inventory unique. Although the authors tried to be general in the scoring system, it is possible that a utility key designed for comparing data sets for use in minority cancer research might be less useful when comparing suicide or heart disease databases. The authors encourage other researchers proceeding with data inventories to find ways of comparing disparate types of data sets, and to express how useful each data set is for the specific type of research being documented. ■

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Special Report:

Laparoscopic Hysterectomy with Bilateral Salpingo-oophorectomy Using a Single Umbilical Puncture

Marco A. Pelosi, MD
Marco A. Pelosi, III, MD

The authors present the first performances of laparoscopic hysterectomy with bilateral salpingo-oophorectomy utilizing a single umbilical puncture. The surgical outcomes demonstrate the success of the single-puncture technique as a safe and effective procedure.

In experienced hands, advanced laparoscopic surgery can be performed effectively with a single umbilical puncture. The feasibility of using this simple approach for complicated surgery (such as myomectomy for large pedunculated and intramural myomas, large ovarian cystectomy, salpingo-oophorectomy, ruptured and unruptured ectopic pregnancy, uterosacral nerve ablation, tuboplasty, and extensive adhesiolysis) has been demonstrated.[1] This report introduces the world's first successful use of the single-puncture technique in the performance of laparoscopic hysterectomy with bilateral salpingo-oophorectomy. The two patients presented here also were the first two laparoscopic hysterectomies performed in New Jersey.

CASE REPORT 1

A 48-year-old female, gravida 4 para 4, complained of chronic pelvic pain, hypermenorrhea, menorrhagia, and severe dysmenorrhea. General physical examination revealed a very tender asymmetric, fibroid uterus that was 18 weeks in size. Examination of the right adnexa demonstrated the presence of a 5 x 6 cm tender, cystic mass. The physicians found no uterine descensus or pelvic relaxation. A pelvic sonogram confirmed the presence of a nonsuspicious right ovarian cyst and a large fibroid uterus. The CA_{125} and all other laboratory tests were normal. Past medical history was unremarkable. A dilation and curettage (D&C) and cervical biopsy had been performed by another gynecologist two months previous to the examination. A benign proliferative endometrium and chronic cervicitis were found.

General anesthesia with endotracheal intubation was administered. An 18 French Foley catheter was inserted into the bladder. Following the placement of an intrauterine cannula for facilitation of uterine manipulation, a deep Trendelenburg position was employed.

The pneumoperitoneum was created using a Verres needle through an intraumbilical puncture. A vertical intraumbilical incision was made. A trocar (enabling the accommodation of a 10 mm operative laparoscope with a 5 mm operating channel) was introduced. A high-flow CO_2 insufflator was utilized. A beam-split video coupler system was attached to the single-puncture laparoscope (Figure 1). Standard operative laparoscopic techniques and instruments, including unipolar and bipolar electrosurgery, were utilized. No secondary punctures were made at any time (Figure 2).

Upon initial laparoscopic inspection, the right ovary was found to be surrounded by adhesions and to contain a benign-appearing ovarian cyst measuring 5 x 6 cm. In addition, multiple large intramural myomas were present in a large, asymmetrical uterus that was 18 weeks in size.

Standard surgical steps of a traditional abdominal hysterectomy were performed through the 5 mm operative channel of the laparoscope. The utero-ovarian ligaments, round ligaments, proximal end of the fallopian tubes, and broad ligaments were grasped and coagulated, using bipolar coagulation forceps. This was followed by dissection and transection with scissors (Figure 3). The vesicouterine peritoneal fold was opened with a unipolar cutting needle. Scissors and hydro-dissection were employed to separate the bladder from the uterus and upper vagina. The bladder was distended partially by instilling a methylene blue solution through the Foley catheter to facilitate the identification of anatomical landmarks and the prompt recognition of inadvertent bladder injury during dissection.

Following skeletonization, the

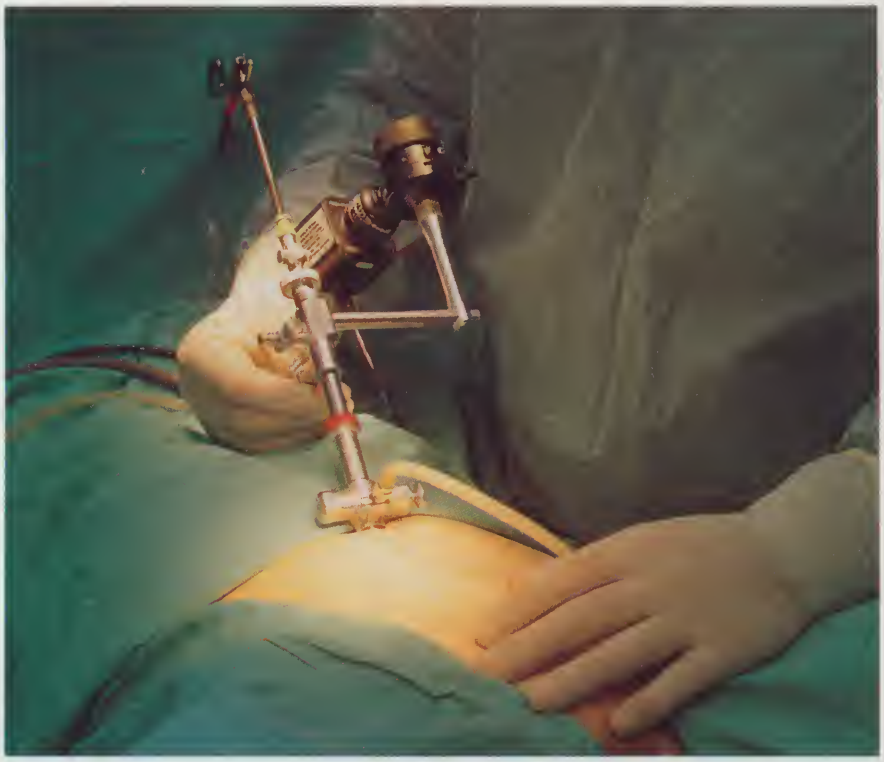


Figure 1. The operative laparoscope was introduced through the umbilicus. Instruments were placed through the operating channel. A beam-split video coupler system was attached to the laparoscope.

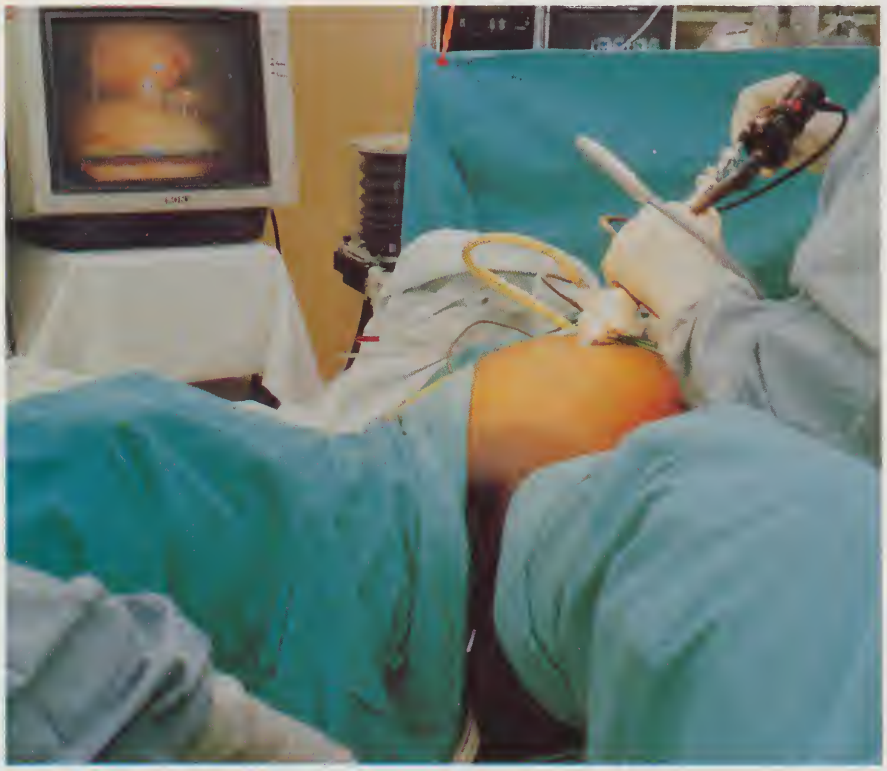


Figure 2. Single-puncture laparoscopic hysterectomy was performed under video guidance.

uterine vessels were coagulated and transected. The cardinal and uterosacral ligaments, and the cervical branches of the uterine arteries were coagulated and subsequently transected (Figures 4 and 5). Through the laparoscope, a unipolar knife was used to open the vagina anteriorly and to produce a posterior colpotomy.

Due to the large size of the fibroid uterus and the lack of vaginal relaxation, morcellation and enucleation of the myomas through the vaginal route was found to be impractical. Alternatively, the cervix was grasped with tenacula and the uterus was pulled downward vaginally. This maneuver created a "plugging" effect of the vagina cuff, allowing the maintenance of an adequate pneumoperitoneum by preventing the vaginal escape of CO_2 gas.

Laparoscopic enucleation of the multiple large myomas then was performed by utilizing the unipolar knife electrode (Figure 6). The myomas and the uterus were delivered vaginally under laparoscopic surveillance (Figure 7). The vagina then was packed with a laparotomy sponge to re-establish a seal to prevent further loss of CO_2 gas from the peritoneal cavity. The pneumoperitoneum was restored. After fine-needle aspiration of the right ovarian cyst, a laparoscopic bilateral salpingo-oophorectomy was performed using bipolar forceps and scissors. Both ovaries and tubes were delivered vaginally.

The lower portion of the cardinal ligaments and uterosacral ligaments were identified through the vaginal cuff and sutured into each cuff angle. The vaginal cuff was closed in a transverse fashion with 0 vicryl suture (Figure 8). The pneumoperitoneum was re-created, a lavage of the peritoneal cavity was done, and hemostasis was confirmed. The umbilical incision then was closed with a 3-0 vicryl suture and the Foley catheter was removed (Figure 9).

Preoperative prophylactic antibiotic therapy was used (Unasyn®—ampicillin sodium/sulbactam sodium). The estimated blood loss was 150 cc. The patient had an uncomplicated postoperative recovery period and was discharged on the third postoperative day. The patient resumed regular activities ten days after surgery. Followup at eight months demonstrated a completely healed and well-supported vaginal cuff.

CASE REPORT 2

A 44-year-old female, gravida 0 para 0, was seen on a referral basis to determine the feasibility of laparoscopic hysterectomy. Her chief complaints were very heavy, painful periods accompanied by incapacitating chronic pelvic pain. The general physical examination essentially was normal. The pelvic examination revealed a very tender and poorly mobile fibroid uterus of approximately 14 weeks in size. The physicians found no uterine descensus or pelvic relaxation. Both adnexa were tender to palpation but no masses were found. Pelvic sonography confirmed the presence of a large fibroid uterus. Standard laboratory tests and CA_{125} were in the normal range. Her past medical history was unremarkable. A D&C was performed and revealed a benign proliferative endometrium, and normal endocervical and ectocervical tissue. Because of several relative contraindications for using the vaginal approach—a large and fixed uterus, nulliparity, possibility of chronic pelvic inflammatory disease, and the absence of uterovaginal prolapse—a laparoscopic hysterectomy with bilateral salpingo-oophorectomy was offered to the patient as an alternative.

Under general anesthesia with endotracheal intubation, a laparoscopic approach similar to that used in the previous case was employed. The initial laparoscopic inspection revealed the presence of chronic pelvic inflammatory disease, extensive adhesions, and a large leiomyomata uterus. Adhesiolysis using bipolar coagulation forceps and scissors was performed. The right infundibulopelvic ligament and the round ligament were sequentially coagulated and transected. A similar procedure was done on the left side. The bladder was partially distended with methylene blue solution, and, using scissors, the vesicouterine fold was opened. Hydro-dissection was employed to separate the bladder from the uterus. The posterior leaf of the broad ligament was dissected with scissors down to the uterosacral ligaments. The uterine vessels were skeletonized and then coagulated and transected. In a similar fashion, the cardinal and uterosacral ligaments were severed. The unipolar knife electrode was used through the laparoscope to create the posterior and anterior colpotomy. The cervix then was grasped with two heavy tenacula and the uterus was pulled downward. The uterus and adnexa were delivered transvaginally under laparoscopic control. The uterosacral ligaments and the lower portion of the



Figure 3. The right round ligament and tube were coagulated and transected. Following coagulation, the right utero-ovarian ligament was transected.



Figure 4. The dissected left uterine artery was seen clearly prior to coagulation and transection.

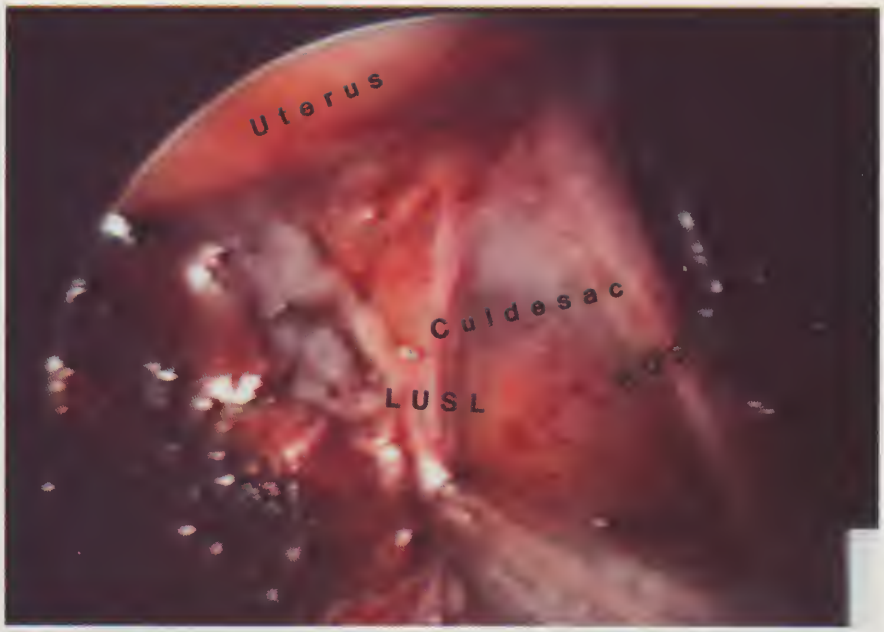


Figure 5. The left uterosacral ligament (LUSL) was coagulated. Note the right uterosacral ligament (RUSL).

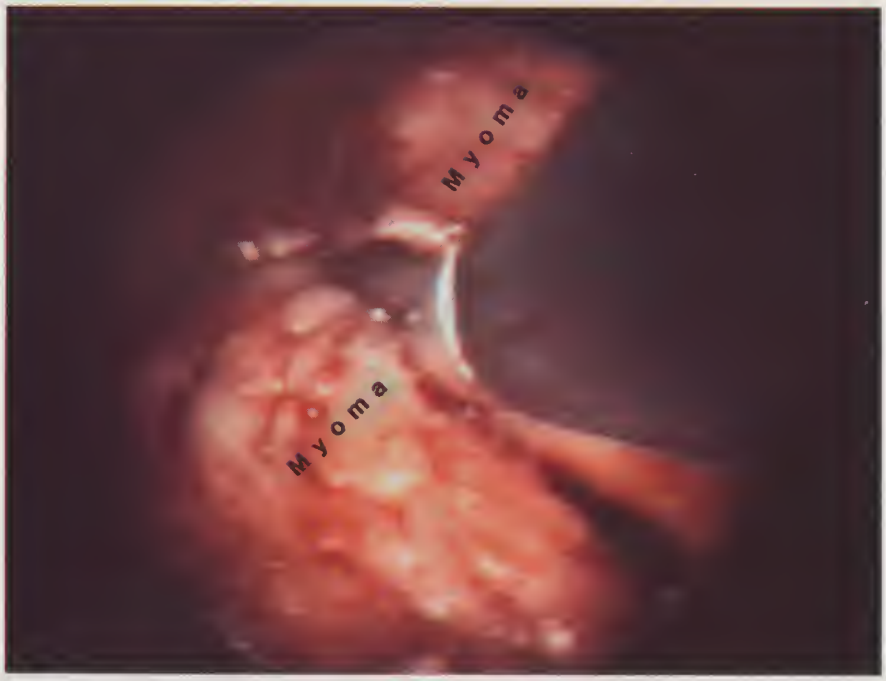


Figure 6. Laparoscopic morcellation of a large myoma.

cardinal ligaments were sutured vaginally into each cuff angle. The vaginal cuff was closed in a vertical fashion with 0 vicryl sutures. Lavage of the peritoneal cavity with three liters of irrigation solution was done after the re-establishment of the pneumoperitoneum. The umbilical incision was closed with 3-0 vicryl suture and the bladder catheter removed (Figure 10).

The estimated blood loss was 100 cc. Prophylactic antibiotic therapy was used (Unasyn®—ampicillin sodium/sulbactam sodium). The patient had an uncomplicated postoperative recovery and was discharged on postoperative day 2. The patient was able to resume normal activities 12 days after surgery. Followup at eight months revealed the patient to have a well-supported and healed vaginal cuff.

DISCUSSION

Most hysterectomies are performed abdominally. The surgical incision, created either horizontally on the lower abdomen, or vertically, is six to eight inches in length. The average hospital stay is five days, with resumption of work and normal daily activities after four to eight weeks.

In comparison to abdominal hysterectomy, vaginal hysterectomy is associated with a significant overall lower postoperative complication rate, a faster and less painful recovery period, and the avoidance of an abdominal scar. As a result, vaginal hysterectomy is the preferred approach when a hysterectomy is indicated. It may, however, be quite difficult to remove the uterus safely through the vagina if the following conditions exist: an enlarged uterus with myomas; a fixed uterus due to adhesions; associated ovarian or tubal pathology; a narrow vaginal canal; and absence of uterine descensus.

For those women in whom the safe transvaginal removal of the uterus and adnexa are considered too risky and too difficult, laparoscopic surgery offers the opportunity to significantly reduce the number of abdominal hysterectomies. In those patients who traditionally would not be considered candidates for safe vaginal hysterectomies, operative laparoscopy obviates the necessity to create the traditional large laparotomy incision. In performing laparoscopy, surgical steps similar to traditional abdominal hysterectomy with salpingo-oophorectomy are effected prior to removal of the surgical specimen through the vagina. Similarly, this new modality is a functional alternative to a technically difficult vaginal hysterectomy, by avoiding a prolonged operative time, excessive blood loss, and an increased chance of injuring the urinary and lower intestinal tracts. This undesirable overall increased risk in postoperative complications frequently leads to an extended postoperative recovery period and a prolonged hospitalization.

Since the original report by

Reich in 1988, clinical studies have shown superior results and the superiority of laparoscopic hysterectomy to the traditional abdominal hysterectomy and to purely vaginal, technically complicated cases.[2] These preliminary series reveal that the laparoscopic hysterectomy is a safe and effective surgical alternative. The procedure is associated with minimal blood loss, short recovery period and hospital stay, minimal complication rate, and significant decrease in postoperative discomfort.[3-7] These uniform results have been obtained using different techniques, i.e. electrosurgery and scissors, lasers, staples, endosutures, or a combination of techniques.

The dramatic postoperative improvement witnessed in patients who have undergone laparoscopic hysterectomy when compared to the traditional abdominal or vaginal method is attributed to the following: 1) elimination of a large abdominal incision; 2) minimal tissue trauma due to finer instrumentation; 3) reduced tissue reaction due to minimal use of suture material; and 4) no interference in bowel function resulting from the avoidance of abdominal retractors, packing, and gross bowel manipulation.

CONCLUSION

All of the laparoscopic hysterectomies reported have been performed using multiple punctures. This presentation introduces the use of the single-puncture technique for the performance of laparoscopic hysterectomy and bilateral salpingo-oophorectomy, demonstrating that complicated laparoscopic surgery does not require the routine, simultaneous use of several instruments. Laparoscopic hysterectomy and salpingo-oophorectomy can be performed in a safe and efficacious manner with this simplified approach, avoiding potential complications associated with multiple punctures such as: bleeding, inadvertent puncture of pelvic structures, wound infection, and hernias. In addition, it offers a faster postoperative recovery, improved cosmetic results, greater patient acceptance, and the flexibility of being converted into a multiple-puncture laparoscopy or a laparotomy when indicated. ■



Figure 7. The uterus was delivered vaginally under laparoscopic surveillance.



Figure 8. The vaginal cuff was closed with absorbable sutures.

Dr. Pelosi is associate clinical professor, UMDNJ-New Jersey Medical School; director, Obstetrics/Gynecology Department, Bayonne Hospital,

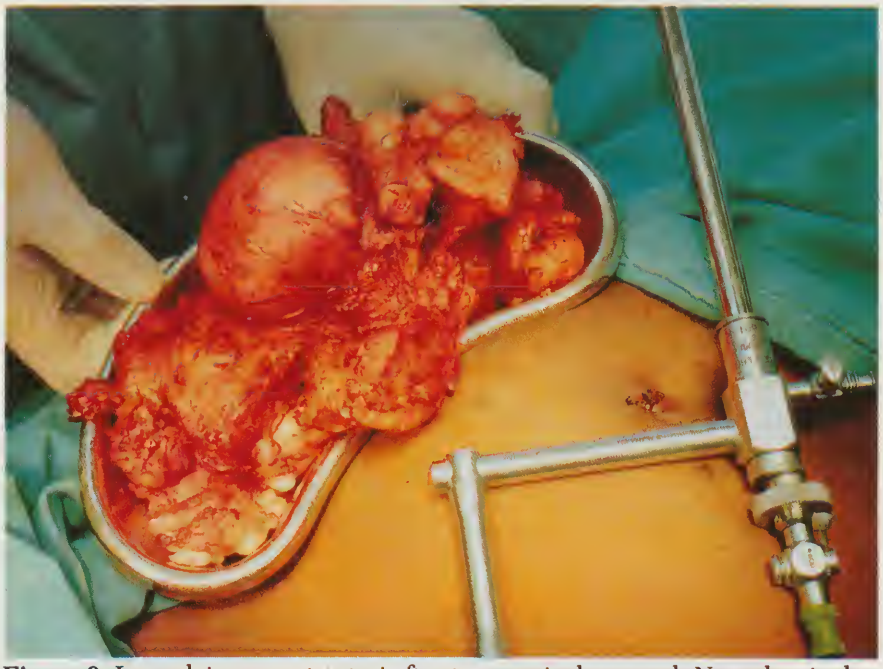


Figure 9. Large leiomyomata uteri after transvaginal removal. Note the single umbilical puncture site.



Figure 10. The enlarged fibroid uterus and adnexa were seen after transvaginal removal. Note the single umbilical puncture site.

Bayonne; and director of the Pelosi Women's Medical Center, Bayonne. Dr. Pelosi, III, is affiliated with the Department of Obstetrics and Gynecology, New York Infirmary-Beekman Downtown Hospital, New York. This special report was submitted in September 1991. Requests for reprints may be addressed to Dr. Pelosi, Pelosi Women's Medical Center, 350 Kennedy Blvd., Bayonne, NJ 07002.

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Tonsillar Polypoid Lymphangioma in a Small Child

John Kasznica, MD
Aleksandra Kasznica, MD

The authors report a case of an unusual tonsillar polypoid lymphangioma in a three-year-old child. A discussion of the possible mechanisms of its pathogenesis is included, as well as a review of the literature of benign lymphangiomatous tonsillar lesions.

Benign tumors of the tonsils include papillomas (the most common benign neoplasm), fibromas, lipomas, adenomas, myxomas, chondromas, neurilemmomas, hemangiomas, and lymphangiomas.[1-4]

There are very few reported cases of polypoid lymphangiomas of the tonsils. To the best of our knowledge, there are no well-documented cases of this lesion in the pediatric age group in the English language literature.

CASE REPORT

A three-year-old boy was examined by a consultant otolaryngologist for recurring bouts of bilateral serous otitis media. During the physical examination, the adenoids were found to be significantly enlarged, and a right tonsillar polypoid lesion was noted. Both middle ears showed fluid behind the tympanic membranes. There was evidence of mild pharyngitis. The rest of the physical examination and the preoperative laboratory workup were unremarkable.

The patient underwent an adenoidectomy, myringotomy with bilateral tube placement, and removal of the tonsillar lesion; there were no postoperative ill effects.

PATHOLOGIC FINDINGS

Tissue examination of the adenoids showed hyperplastic and reactive changes.

The polypoid lesion, cylindrical with a short narrow stalk, measured 1.2 cm in length and 0.4 cm in diameter. It was rubbery, slightly orange-pink, and homogenous on gross section. Step serial microscopic sections showed subtle cortical and medullary components that merged imperceptibly into one another (Figure 1). Multiple vascular channels were seen, especially in the central portion (Figure 2), and were filled with monotonous appearing lymphocytes. There was a sprinkling of central capillaries. The entire structure was lined by stratified squamous epithelium. An espe-



Figure 1: The pedunculated lesion with delicate stalk is seen on longitudinal section. The stalk is not continuous and is better seen on the tonsillar point of attachment near the lower left corner of the illustration (arrow). Lymphatic channels readily are noted in the lesion's midsection (scanning power, hematoxylin-eosin).

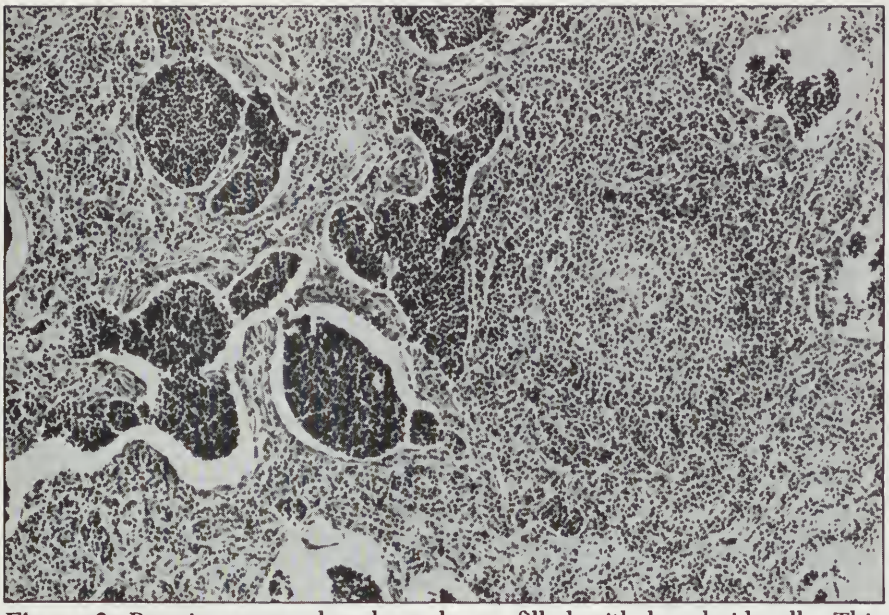


Figure 2: Prominent vascular channels are filled with lymphoid cells. This architectural pattern is representative of the central portion of this lesion. No significant fibroadipose stromal component was seen (x 240, hematoxylin and eosin).

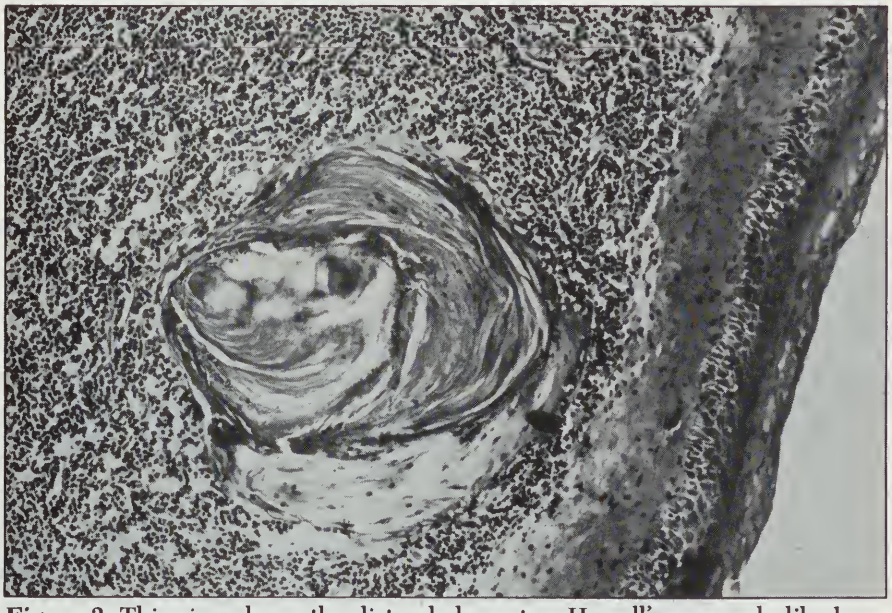


Figure 3: This view shows the distended crypt or Hassall's corpuscle-like horn cyst and the adjacent stratified squamous epithelial lining of the polypoid lesion (x 240, hematoxylin and eosin).

cially curious finding was the presence of a distended crypt or "horn cyst" with a Hassall's corpuscle appearance (Figure 3).

DISCUSSION

Benign tumors of the tonsils rarely are cited in the medical literature. The most common tumors are papillomas. Angiomas, as a group, represent only 39 of 381 cases on file with the Otolaryngic Pathologic Registry of the Armed Forces Institute of Pathology (10 percent as compared to 75 percent for squamous papilloma). Lymphangiomas outnumber the other "angiomas"; this probably is due to local anatomic factors.[1,3]

This present case particularly is interesting because of the patient's age. All previously documented and reviewed cases were found in patients ranging in age from 18 to 35 years.[1,5]

The lesion already was well developed, and polypoid in this three-year-old child. The lesion was similar to other lesions noted in the literature, except for the lack of fibroadipose stromal component. This is a significant difference, as most reported cases describe the presence of fibroadipose tissue.[1]

The pathogenesis is a combination of factors, acting simultaneously: first, the presence of a hamartomatous, possibly choristomatous, nidus with its own growth potential, as postulated by Ash and Raum, and second, the growth phase responsible for the eventual polypoid manifestation spurred by chronic inflammation as suggested by Visvanathan.[4,5]

The eventual appearance of the fibroadipose stroma may be a reflection of an involutional process taking place within the vascular/lymphatic growth. Alternately, if the fibroadipose component is congenitally present within the lesion nidus, this may be considered a choristomatous focus, since a fibroadipose vascular core is not a usual anatomic feature of normal tonsils.

On the other hand, the hamartomatous origin of the lesion is supported by the presence of tissue elements normally found in that topographic region of the body with the exception of lymphatic sinuses.[4] However, even this exception may be explained to some extent by existing anatomic evidence, because, in the normal histology of the tonsil, blindly ending lymphatic capillaries are seen and surround the outer surface.[6] Anatomically, this corresponds to the site where the polypoid lesions may arise. The hamartomatous concept of the lesion's origin may explain the "reorganized" appearance of the polypoid lesion vis-a-vis tonsillar hyperplasia.

In relative unilateral hyperplasia (where both tonsils are unequally enlarged), aside from its size, the larger tonsil would architecturally remain the same, but would contain more cells and reactive lymphoid follicles. No concomitant angioma (whether

lymphoid or vascular) would be noted in a typical hyperplasia.

As to the presence of the distended crypts or horn cysts, this finding agrees with the hamartomatous and possibly congenital nature of the nidus, considering crypts are an integral anatomic feature of tonsils and that palatine tonsils are lined by stratified squamous epithelium.

The above structures probably are not Hassall's corpuscles; if they were aberrant forms, they could not be entirely dismissed on an embryological basis because of the cervical origin of the thymus. Ectopic thymus tissue admittedly is very rare in the upper neck as compared to the lower neck.[7] The presence of isolated Hassall's corpuscles has not been described.

The tonsillar lymphangioma is clearly a rare lesion, and may be under reported.[1,3] It should be stressed that in many community hospitals, pediatric age hyperplastic tonsils are only examined grossly. Perhaps, on careful examination with step serial sections, early microscopic lymphangiomatous foci might be identified in routine tonsillectomy specimens. ■

Drs. Kasznica are affiliated with the Mallory Institute of Pathology and the Department of Pathology, Monmouth Medical Center, Long Branch. The paper was submitted in February 1991 and accepted in May 1991. Requests for reprints may be addressed to Dr. John Kasznica, Mallory Institute of Pathology, 784 Massachusetts Avenue, Boston, MA 02118.

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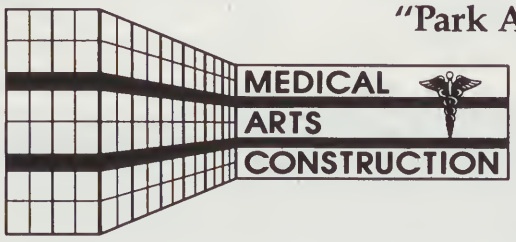
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Small Cell Carcinoma of the Prostate with Adenocarcinoma of the Rectum

Khin M. Nyi, MD
Anis F. Rangwala, MD

Our case of a pure small cell carcinoma of the prostate was found concomitantly and separately from an adjacent primary adenocarcinoma of the rectum. There was no evidence of adenocarcinomatous differentiation in the prostate tumor and no primary small cell carcinoma was detected in other organs.

Reports of primary extrapulmonary small cell carcinoma with histological features indistinguishable from bronchogenic small cell carcinoma are being published with increasing frequency.[1-8] The tumor has been described in the upper aerodigestive tract, salivary glands, pancreas, uterine cervix, breast, urinary bladder, and prostate.[1,2,5,7]

Small cell carcinoma of prostate is rare and has been reported with the usual prostatic adenocarcinoma.[5,7] Of the 35 cases reported, 23 cases were diagnosed initially either as adenocarcinoma admixed with small cell carcinoma or with small cell carcinoma appearing later.[5,7] The other 12 cases were pure small cell carcinoma of the prostate.[3,4,6,8]

There has been no report until now of a pure small cell carcinoma of prostate occurring concomitantly with a non-small cell epithelial malignancy in other organs.

CASE REPORT

A 64-year-old white male with a history of coronary heart disease and coronary bypass surgery was admitted to Monmouth Medical Center in July 1989 for acute onset of left flank pain.

Physical examination revealed a stable cardiovascular status. Intravenous pyelography (IVP) demonstrated an obstruction of the distal left ureter due to an enlarged prostate. Subsequent rectal examinations detected a large colorectal tumor. Needle biopsies of the prostate showed a small cell carcinoma (Figures 1 and 2). Special stains including actin, desmin, prostatic acid phosphatase (PAP), and prostatic specific antigen (PSA) were negative, but neuron-specific enolase stain (NSE) was positive. There was no histological resemblance to the biopsied adenocarcinoma of the rectum that was moderately-well differentiated (Figures 3 and 4). No overt sites of metastases were found, but there was a suspicious lesion in the left 8th rib on chest x-ray. Routine laboratory tests were unremarkable, except for mild anemia (Hgb, 11.5 gm/dl and HCT, 34.1 percent).

The patient received radiation therapy (RT) for the small cell carcinoma of the prostate and RT with chemotherapy for the rectal adenocarcinoma that subsequently was resected in October 1989. A rectosigmoid colectomy was performed in October 1989; it showed an adenocarcinoma that was moderately-well differentiated and extended into the

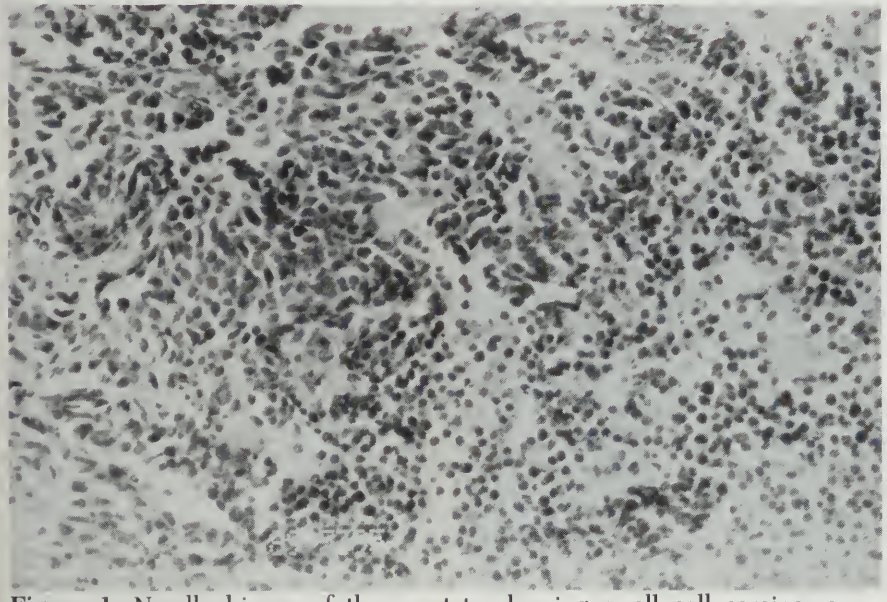


Figure 1. Needle biopsy of the prostate showing small cell carcinoma.

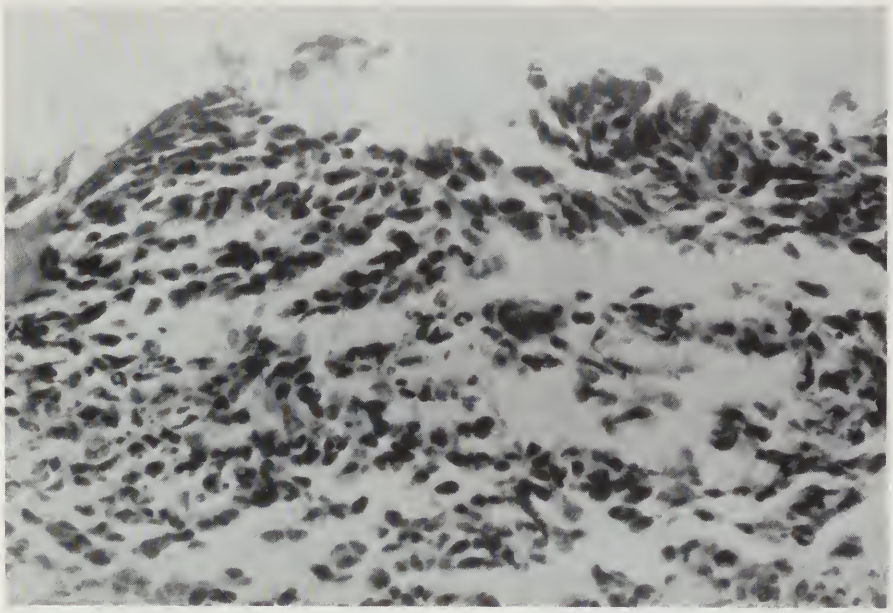


Figure 2. Needle biopsy of the prostate showing small cell carcinoma.

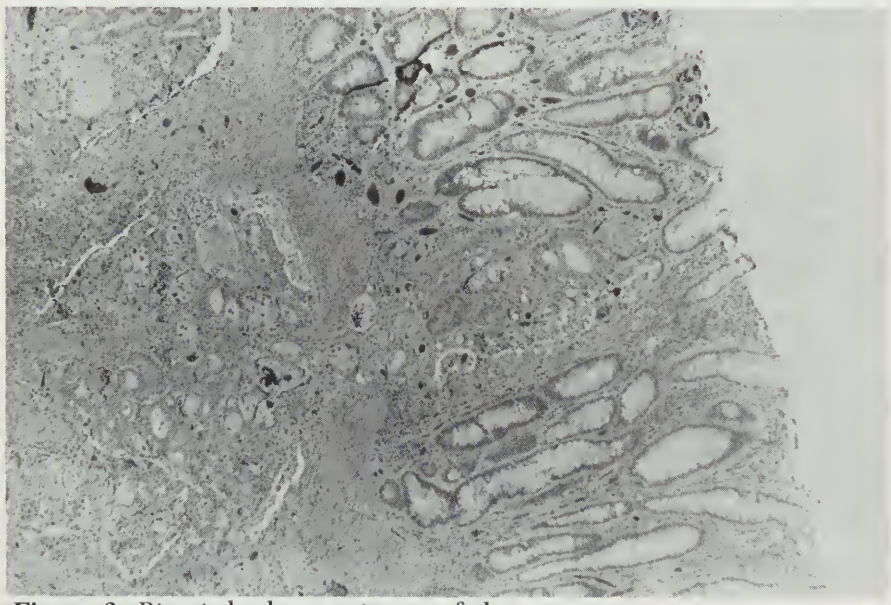


Figure 3. Biopsied adenocarcinoma of the rectum.

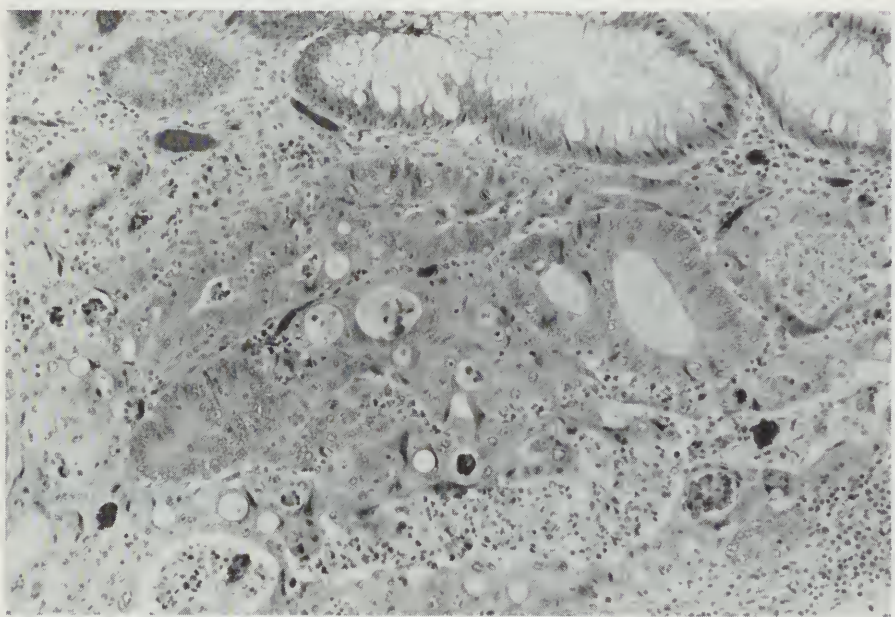


Figure 4. Biopsied adenocarcinoma of the rectum.

perirectal adipose tissue, with metastases to 8 of 11 regional lymph nodes. The postoperative period was uneventful.

In November 1989, after a course of chemotherapy, the patient presented with symptoms of small bowel obstruction that resolved spontaneously. Eleven months after the initial diagnosis and eight months after chemotherapy, the patient presented with a retroperitoneal mass. Aspirate of this mass under computed tomography (CT) scan guidance revealed an undifferentiated carcinoma, small cell type, consistent with metastasis from the prostatic primary (Figures 5 and 6).

DISCUSSION

The histological features of the prostatic tumor bore no resemblance to the moderately well-differentiated adenocarcinoma of the rectum. There was no evidence of adenocarcinomatous differentiation in the prostatic tumor. The adenocarcinoma of the rectum, classified as a Duke's Class C with metastasis to 8 of 11 regional lymph nodes, was situated close to the prostate anatomically, but developed apart from it. The prostatic tumor was composed of uniform, small malignant cells measuring up to two times the diameter of normal lymphocytes, having round to oval nuclei with evenly distributed chromatin and scanty cytoplasm. The nuclei showed molding and, in places, the tumor cells were present in festoons and ribbons. There was tumor necrosis that often is associated with aggressive, fast-growing tumors. The immunohistochemical staining characteristics were extensively studied by Ro and colleagues in 18 cases; they observed three staining characteristics among small cell carcinomas of the prostate: NSE and negative staining with PSA and PAP.[8] Similar observation was made by Schron regarding the PSA staining.[5] In the present case, there were similar findings with NSE (positive staining) and

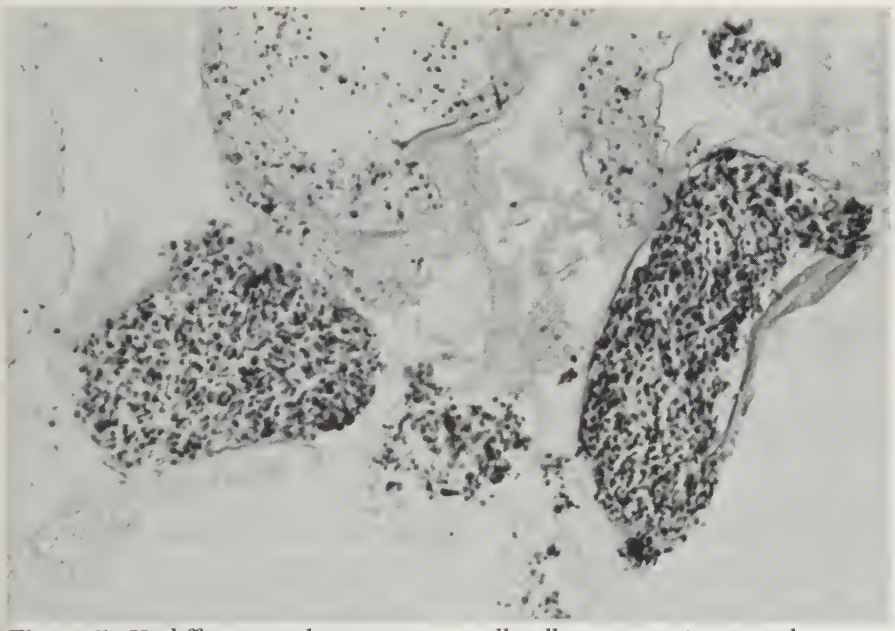


Figure 5. Undifferentiated carcinoma, small cell type, consistent with metastasis from the prostatic primary.

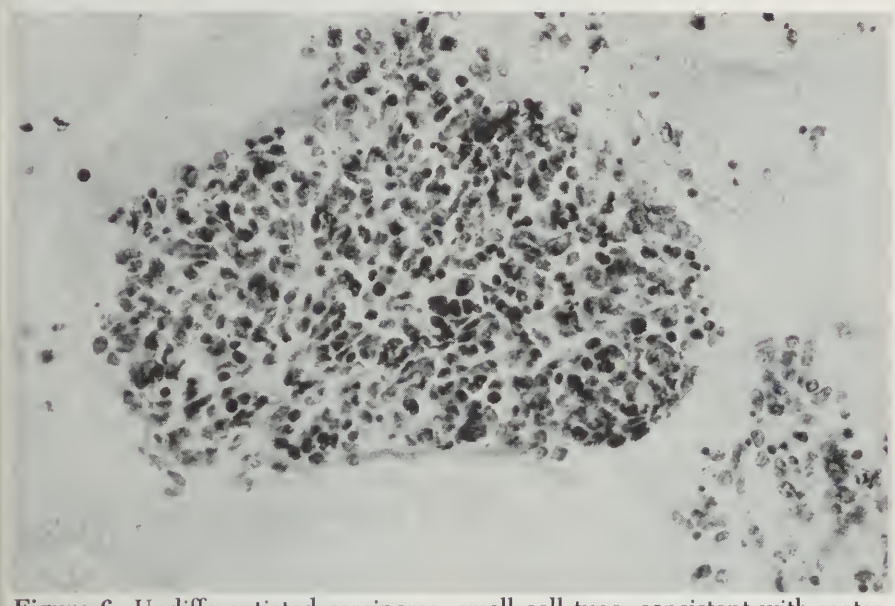


Figure 6. Undifferentiated carcinoma, small cell type, consistent with metastasis from the prostatic primary.

PAP and PSA (negative staining).

Though small cell carcinomas of extrapulmonary sites have been reported with increasing frequency, it is imperative that one exclude the possibility of lung primary in every case. In this case, this was accomplished with routine chest x-rays and CT scans of the lungs. Hodge and Carson mentioned that the prostate is a very rare site for metastasis of small cell carcinoma of the lung.[9]

Tetu mentioned that small cell carcinoma of the prostate may represent an initial event and appear de novo or may occur early in the evolution of the usual adenocarcinoma.[7] Tetu stated that small cell carcinoma may sometimes represent as a late manifestation of the prostatic malignancy. Brawn reported a long interval in the dedifferentiation of adenocarcinoma of the prostate.[10]

CONCLUSION

This is the first case of a pure small cell carcinoma of the prostate found concomitantly and separately from a primary adenocarcinoma of the rectum. The possibility of extension of a tumor should be considered when tumors with differing features exist in close proximity. ■

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Prostatic Cancer: The Case for Conservatism

Robert B. Zufall, MD

Carcinoma of the prostate is the most common malignancy in men. It is the second leading cause of cancer deaths in men, with a five-year survival rate of 72 percent. One asks, "Is the cure necessary in those in whom it may be possible? Is cure possible in those whom it may be necessary?"

Carcinoma of the prostate is the most common malignancy in men. It is the second leading cause of cancer deaths in men, with an overall five-year survival rate of 72 percent. New diagnostic and therapeutic weapons are being used, but there is an evolving controversy about their effectiveness. Willett Whitmore asked, "Is cure necessary in those in whom it may be possible? Is cure possible in those in whom it may be necessary?"

Carcinoma of the prostate is variable. Its aggressiveness correlates with the Gleason scale. Many older men have cancer of the prostate but die of other diseases. On the other hand, there is a small percentage of men whose cancers are discovered, treated early, and cured. Jewett did the definitive study of radical prostatectomy in men who had a small localized nodule. These men had a 15-year survival rate, as good as the normal population, but only a few months better than men with localized nodules who were not treated. There are costs: impotence, even with nerve-sparing surgery; incontinence; and small operative morbidity and mortality.

Radiation therapy has been used successfully; it seems to be almost as effective as surgery, but with complications. Palliative radiation for the pain of bony metastases, on the other hand, is very effective.

Huggins became famous when he removed the testes of men with more advanced cancer; these men had impressive symptomatic improvement. It is hard to demonstrate increased longevity. The cancer goes into remission, yet it does return. There seems to be evidence of improved survival that is measured in months.

Diethylstilbestrol accomplished the same thing as orchiectomy, but at a cost of increased vascular disease. It has been suggested that 1 or 2 mg/day may control the cancer (as compared to 5 mg/day) without the vascular complications. The LHRH agonists, leuprolide (Lupron®), goserelin (Zoladex®), and others, are as effective as diethystilbestrol without the vascular effects; they also cost about $300 a month. The anti-androgens, flutamide (Eulexin®) and others, have the advantage of blocking adrenal as well as testicular androgen; there are questions about the significance of the advantage. It has been hard to show any advantage of early over late hormonal therapy, and physicians have advocated not using it until necessary. There is evidence of survival for a few months with early treatment.

Transrectal ultrasound, especially with needle biopsy, can detect a few more cancers than the standard rectal examination. Prostate specific antigen (PSA) is considered normal if it is under 4, and diagnostic of metastases is normal if it is over 40. There is a big questionable area in between these figures, but neither test is routinely advised for screening because of false positives and negatives, the cost (estimated in the $20 billions), the morbidity of treatment in men who might not need prostate surgery, and the lack of improvement in survival.

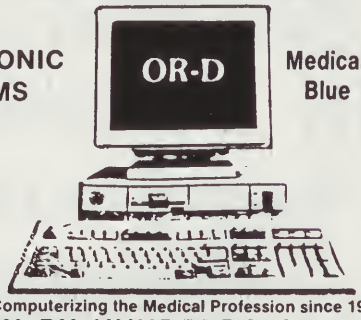
Many well-known urologists go to extremes. Every man with a suspicious nodule undergoes an ultrasound and a biopsy. If localized disease is found, he receives a radical prostatectomy, or radiation. If it is not localized, he receives LHRH and antiandrogens or an orchiectomy and antiandrogens.

If I were 50 and had a localized nodule, I would think a bit about a radical. But I am 65, and if I have an asymptomatic cancer in my prostate, I do not want to know about it. ■

Dr. Zufall is a member of our Editorial Board. Requests for reprints may be addressed to Dr. Zufall, 64 Baker Avenue, Dover, NJ 07801.

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Entries must be submitted by December 1, 1991. The winning paper will be published in a future issue of NEW JERSEY MEDICINE. Other noteworthy manuscripts will be considered for publication by the Editorial Board of NEW JERSEY MEDICINE. Editorial criteria appear at the end of the issue.

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All papers and photographs will be returned. If you have any questions, please call the offices of NEW JERSEY MEDICINE at 609/896-1766.

Legislative Update

SENATE BILLS WITH AN ACTIVE POSITION	MSNJ POSITION	COMMITTEE	STATUS
S-642—Ewing—Commissioner of Health Deletes the requirement of a medical license to be commissioner of health.	Active Opposition	Senate: IHW	Passed in Senate; in Assembly Committee (SOP)
S-1012—Feldman—Medical Malpractice Provides that within 60 days of filing an action against a physician, the plaintiff must provide an affidavit from an expert that there has been a negligent deviation from the accepted standards of practice.	Active Support	Senate: JUD	In Committee
S-1208—Ambrosio—Declaration of Death Sets forth the criteria to be recognized for a declaration of death. Neurological criteria may not be used if they violate the personal religious beliefs or moral convictions of the individual.	Active Opposition	Senate: JUD	Signed into law, Ch. 90, P.L. 1991
S-1230—Codey—Certificate of Need Amends the certificate of need law to include physicians whenever a health service has been regionalized by regulation of the New Jersey State Department of Health. Regulations would terminate within three years, at which time, the commissioner could readopt the regulation.	Active Opposition	Senate: IHW	In Committee
S-1233—Codey—Mental Health Coverage Requires health insurers to provide coverage for mental illnesses.	Active Support	Senate: LIP	In Committee
S-1234—Codey—Mental Health Coverage Requires health insurers to provide coverage for mental illnesses.	Active Support	Senate: LIP	In Committee
S-1235—Codey—Mental Health Coverage Requires health insurers to provide coverage for mental illnesses.	Active Support	Senate: LIP	In Committee
S-1236—Codey—Mental Health Coverage Requires health insurers to provide coverage for mental illnesses.	Active Support	Senate: LIP	In Committee
S-1237—Codey—Mental Health Coverage Requires HMOs to provide coverage for mental illnesses.	Active Support	Senate: LIP	In Committee
S-1238—Codey—Mental Health Coverage Requires health service corporations to provide coverage for mental illnesses.	Active Support	Senate: LIP	In Committee
S-1556—Cardinale—Certificate of Need Exempts the private practice of medicine from the certificate of need law.	Active Support	Senate: IHW	In Committee
S-1587—Cardinale—Determination of Death Establishes criteria and procedures for determination of death. Creates a religious belief exemption regarding neurological factors.	Active Opposition	Senate: JUD	In Committee

S-1791—Zane—Unemployment Compensation and Disability Benefits Exempts physicians who are independent contractors from employment and disability taxes. Clarifies an ambiguity in the current law.	Active Support	Senate: LIP	In Committee
S-1810—Bennett—Licensing of Health Professionals Requires statutory authorization for the licensure or certification of health care practitioners.	Active Support	Senate: IHW	In Committee
S-1864—Dumont—Statute of Limitations Provides for a three-year statute of limitations, except for fraud, intentional concealment, or nontherapeutic or diagnostic purpose. Minors would have until age 11 on any injury prior to age 8.	Active Support	Senate: JUD	In Committee
S-1975—Orechio—Medicare Assignment Requires health care licensees to accept Medicare determination of their fees.	Active Opposition	Senate: IHW	In Committee
S-2016—Contillo—National Health Care Provides for a nonbinding referendum concerning the enactment of a national health plan.	Active Opposition	Senate: IHW	Signed into law, Ch. 160, P.L. 1991
S-2100—Lipman—Nursing Practice Authorizes nurses to practice medicine and to prescribe drugs and devices.	Active Opposition	Senate: LIP	In Committee
S-2224—Dalton—Medical Expenses in Auto Accidents Requires health providers to directly bill auto carriers when there is applicable PIP coverage.	Active Opposition	Senate: LIP	In Committee
S-2225—Dalton—Medical Expenses in Worker's Compensation Requires health providers to directly bill the employer or the compensation carrier whenever worker's compensation insurance is applicable.	Active Opposition	Senate: LIP	In Committee
S-2329—Lipman—HIV Reporting Amends recently adopted law and removes HIV sensitivity as a reportable matter.	Active Opposition	Senate: IHW	Passed in Senate; amended; in Assembly Committee (HHS)
S-2546—Lynch—Contact Lens Dispensing Provides for the regulation and certification of contact lens dispensers by the Board of Ophthalmic Dispensers and Technicians.	Active Opposition	Senate: LIP	Out of Committee; 2nd reading
S-2583—Feldman—Social Workers Licenses the practice of social workers and includes the diagnosis and treatment of mental and emotional disorders and the use of psychotherapy.	Active Opposition	Senate: IHW	Signed into law, Ch. 134, P.L. 1991
S-2607—Codey—Licensure/Burden of Proof Raises the standard of proof in medical and podiatry disciplinary proceedings to "clear and convincing."	Active Support	Senate: IHW	Passed in Senate; in Assembly Committee (CRP)
S-2637—Dalton—Structured Verdicts Provides for structured verdicts when future damages exceed $250,000.	Active Support	Senate: JUD	In Committee
S-2648—Girgenti—County Ombudsman Creates a county ombudsman system to serve as an investigational and enforcement arm of the State Of-	Active Opposition	Senate: RVA	In Committee

fice of the Ombudsman for the Institutionalized Elderly. It would be up to each county to decide whether to participate. The state would reimburse one-half the operating expenses.

S-2704—Paterniti—Orthotists and Prosthetists

Provides for the licensing of orthotists and prosthetists by the Division of Consumer Affairs. A nine-member advisory committee would assist the director. Two of the nine members would be physicians.

Active Opposition | Senate: LIP | Out of Committee; amended; 2nd reading

S-2751—Cardinale—Physical Therapy Assistants

Provides that a physical therapy assistant may be employed by a physician, podiatrist, or chiropractor to administer ultraviolet and electromagnetic rays, deep heating agents, diathermy, and ultrasound.

Active Support | Senate: LIP | In Committee

S-3033—Orechio—Worker's Compensation (same as A-4057)

Requires that when an employer provides a list of designated physicians, at least one chiropractor must be included.

Active Opposition | Senate: LIP | In Committee

S-3218—Rice—HIV Testing

Any person convicted of sexual assaults must be tested for HIV sensitivity, and the results of the test are to be disclosed to the victim.

Active Support | Senate: JUD | In Committee

S-3251—Codey—Health Care Reform

A sweeping omnibus bill that, among other things, applies certificate of need to doctors, prohibits doctors from referring patients to a service in which they own an interest, prohibits dispensing beyond a four-day supply, and provides for a holographic override on generic prescriptions.

Active Opposition | Senate: IHW | Signed into law, Ch. 187, P.L. 1991

SCR-84—Zane—Regulation

Provides constitutional amendment that the Legislature by majority vote may override any rule or regulation.

Active Support | Senate: SG | In Committee

ASSEMBLY BILLS WITH AN ACTIVE POSTION	MSNJ POSITION	COMMITTEE	STATUS

A-1—Doria—No-Fault

Revises no-fault. Provides for a $100 per year tax on medical licenses to help offset the JUA deficit, provides for a medical fee schedule at the 75th percentile, and a ban on balance billing.

Active Opposition | Assembly: AP | Signed into law, Ch. 8, P.L. 1990

A-31—Kavanaugh—Commissioner of Health

Changes qualifications for commissioner of health and prescribes qualifications for deputy commissioner of health.

Active Opposition | Assembly: HHS | In Committee

A-234—Naples—Health Care Services

Bars actions to enforce the payment of bills for health care services for 60 days under certain circumstances.

Active Support | Assembly: INS | In Committee

A-264—Naples—Medical Records

Would require that records be "furnished upon request to the patient and/or his duly authorized representative immediately."

Active Opposition | Assembly: HHS | In Committee

A-325—Deverin—Occupational Therapy Creates a new class of licensed practitioners who would function independently and would be permitted to perform such services as the design, fabrication, and application of splints, sensorimotor activities, the use of specifically designed crafts, guidance in the selection and use of adaptive equipment, therapeutic activities to enhance functional performance, prevocational evaluation and training, and a consultation concerning the adoption of physical environments for the handicapped. The State Board of Medical Examiners will exercise jurisdiction.	Active Opposition	Assembly: CRP	In Committee
A-346—Deverin—Respiratory Therapists Creates a Board to license and regulate respiratory therapists. Services are to be provided under the direction or supervision of a physician.	Active Opposition	Assembly: CRP	Signed into law, Ch. 31, P.L. 1991
A-366—Colburn—Corrective Lenses Prohibits the mail order sale of prescription lenses.	Active Support	Assembly: HHS	Passed in Assembly; amended; in Senate Committee (LIP)
A-616—Felice—Contact Lenses Creates a State Board of Examiners of Ophthalmic Dispensers and Ophthalmic Technicians. Permits that Board to license contact dispensers.	Active Opposition	Assembly: CRP	Out of Committee; amended; 2nd reading
A-743—Roberts—Optometric Use of Drugs Permits optometrists to use and prescribe drugs.	Active Opposition	Assembly: CRP	Out of Committee; amended; 2nd reading
A-1357—Bryant—Warning Labels Requires warnings labels about the dangers of alcohol use by pregnant women.	Active Support	Assembly: DAP	Out of Committee; amended; 2nd reading
A-1540—Girgenti—Structured Payments Provides for structured settlements when future damages exceed $150,000.	Active Support	Assembly: JLPS	In Committee
A-1653—Shusted—Structured Payments Provides for structured payments in civil actions against health care providers when future damages exceed $250,000. An annuity must be offered to guarantee the future payments.	Active Support	Assembly: JLPS	In Committee
A-1853—Doria—HMO Ensures HMO enrollees on a form of coverage when using non-HMO providers.	Active Support	Assembly: HHS	In Committee
A-1893—Moran—Medicare Fee Complaints Establishes a public blacklist to be compiled by the Division of Aging on those physicians whose fees exceed Medicare allowances.	Active Opposition	Asembly: SC	In Committee
A-1970—Kelly—Prescription of Drugs by Nurses Allows nurses who practice in collaboration with physicians to prescribe medications in accordance with protocols submitted to and approved by the State Board of Nursing.	Active Opposition	Assembly: HHS	In Committee
A-2019—Ogden—Mental Health Benefits Requires health insurers and HMOs to require specified amounts of mental health benefits as mandated coverage.	Active Support	Assembly: INS	In Committee

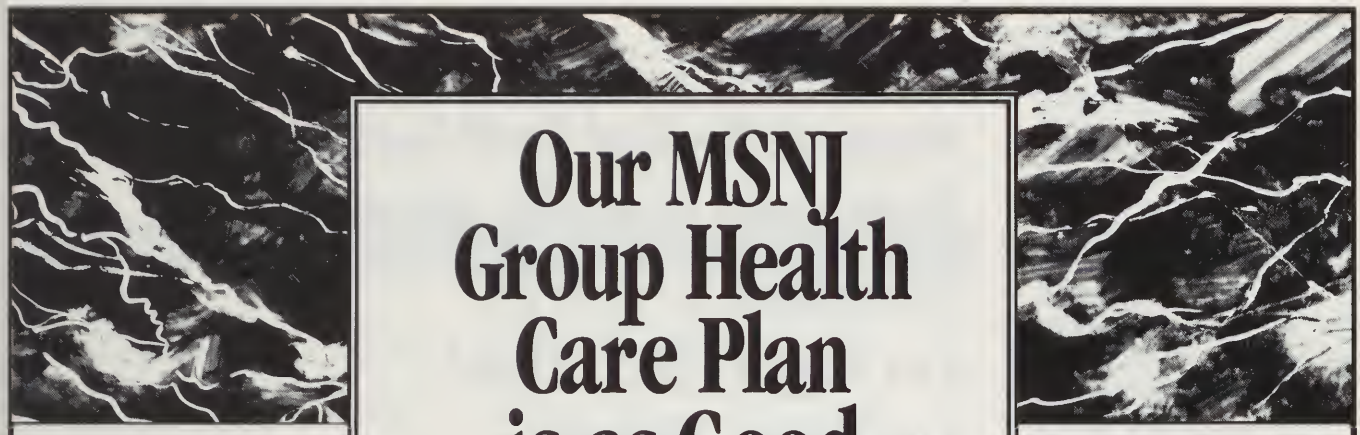
A-2020—Ogden—Mental Health Benefits Same as **A-2019** except it applies to HMOs.	Active Support	Assembly: INS	In Committee
A-2021—Ogden—Mental Health Benefits Same as **A-2019** except it applies to Blue Cross.	Active Support	Assembly: INS	In Committee
A-2022—Ogden—Mental Health Benefits Same as **A-2019** except it applies to individual commercial insurance.	Active Support	Assembly: INS	In Committee
A-2023—Ogden—Mental Health Benefits Same as **A-2019** except it applies to medical service corporations.	Active Support	Assembly: INS	In Committee
A-2024—Ogden—Mental Health Benefits Same as **A-2019** except it applies to Blue Shield.	Active Support	Assembly: INS	In Committee
A-2212—Spadoro—Medical Waste Imposes criminal penalties for illegal disposal of medical waste; increases criminal penalty for illegal disposal of hazardous waste.	Active Opposition	Assembly: WMPR	In Committee
A-2811—Doria—Optometry Amends the optometric act to repeal that section that prohibits optometrists from practicing medicine.	Active Opposition	Assembly: H.Ed	Signed into law, Ch. 171, P.L. 1991
A-3001—Doria—Optometry Same as **A-2811** except it has a revised statement.	Active Opposition	Assembly: CRP	In Committee
A-3042—Bush—Medicare Assignment Requires mandatory assignment for PAAD patients.	Active Opposition	Assembly: HHS	In Committee
A-3289—Patero—Health Insurance for the Unemployed Establishes two state-operated plans for the unemployed. Appropriates $50 million from the State Disability Fund as a start-up loan. Continued funding is provided from the unemployment compensation fund. Anyone collecting unemployment would be eligible for state-sponsored health and life coverage.	Active Opposition	Assembly: LABOR	In Committee
A-3331—Ford—Wrongful Death Makes various changes in the wrongful death act including expansion of recoverable damages.	Active Opposition	Assembly: JLPS	Out of Committee; amended; 2nd reading
A-3355—Bryant—Structured Verdicts Provides for structured verdicts when future damages exceed $250,000.	Active Support	Assembly: JLPS	In Committee
A-3359—Kavanaugh—Triplicate Prescriptions Requires that all schedule II prescriptions be written on state-issued triplicate forms.	Active Opposition	Assembly: DAP	In Committee
A-3529—Impreveduto—Health Licensing Provides that no new category of health practitioners shall be authorized without legislative approval.	Active Support	Assembly: CRP	Out of Committee; amended; 2nd reading
A-3531—Impreveduto—Nurse/Midwives Authorizes nurse/midwives who have registered with the State Board of Medical Examiners to write prescriptions consistent with protocols established by their collaborative physician.	Active Opposition	Assembly: HHS	Signed into law, Ch. 97, P.L. 1991

A-4057—Zangari—Worker's Compensation Permits injured employees to select the physician or chiropractor of their choice if their employer provides a list of approved practitioners.	Active Opposition	Assembly: LABOR	Passed in Assembly; amended; in Senate Committee (LIP)
A-4090—Bryant—Physical Therapy Services Provides that a physical therapist may treat a patient without physician referral.	Active Opposition	Assembly: CRP	Out of Committee; amended; 2nd reading
A-4145—Ford—Commissioner of Health Amends current law to provide the commissioner of health either may be a physician or a nurse.	Active Opposition	Assembly: SOP	In Committee
A-4268—Mullen—Physician Dispensing Prohibits physicians from dispensing more than a four-day emergency supply of drugs except in certain limited instances.	Active Opposition	Assembly: HHS	In Committee
A-4282—(AIC Substitute)—Health Care Reform Omnibus reform bill that would adversely affect physicians by requiring the prescription of generics except when halographically written; would apply certificate of need to physicians at the $1 million threshold.	Active Opposition	Assembly: AP	Amended; in Committee
A-4284—Mullen—Generic Prescriptions Mandates the use of generics unless the prescriber holographically overrides.	Active Opposition	Assembly: HHS	In Committee
A-4303—Catania—HIV Testing Requires that persons convicted of sexual crimes be tested for HIV sensitivity.	Active Support	Assembly: JLPS	In Committee
A-4347—Mullen—Physician Assistants Provides for the registration of physician assistants through a separate Board. A supervising physician is necessary.	Active Opposition	Assembly: HHS	In Committee
A-4367 (ACS)—Bush—Medicare Assignment Mandates acceptance of Medicare rates for seniors with incomes of $34,125 (single) and $41,875 (couple).	Active Opposition	Assembly: AP	In Committee
A-4468—Pelly—Caller I.D. Requires free blocking services for call blocking for unpublished telephone numbers when caller I.D. is in place.	Active Support	Assembly: TATT	In Committee
A-4483—Rooney—Parental Notification for Abortion Requires physicians to give an unemancipated minor's parent or guardian at least 48 hours notice prior to performing an abortion.	Active Opposition	Assembly: JLPS	In Committee
A-4585—Mullen—Nurse Practitioners Authorizes nurses to diagnose and treat and to otherwise practice all licensed health professions.	Active Opposition	Assembly: HHS	In Committee

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Senate Reference Committees
IHW: Institutions, Health & Welfare
JUD: Judiciary
LIP: Labor, Industry & Professions
RVA: Revenue, Finance & Appropriations
CMG: County & Municipal Government
SG: State Government

Assembly Reference Committees
HHS: Health & Human Services
INS: Insurance
CRP: Commerce & Regulated Professions
AP: Appropriations
JLPS: Judiciary, Laws & Public Safety
DAP: Drug and Alcohol Policy
SC: Senior Citizens
WMPR: Waste Management, Planning & Recycling
SOP: State Operations and Personnel
TATT: Transportation Authorities, Telecommunications & Technology
H.Ed: Higher Education



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OFFICIALLY ENDORSED BY MSNJ

The AMA Hospital Medical Staff Section Eighteenth Assembly Meeting December 5 - 9, 1991 Las Vegas Hilton Hotel Las Vegas, Nevada

Highlights of the Interim Meeting will include:

- an educational program on RBRVS: Physician Payment Reform or Retribution;
- presentation by the AMA-HMSS Governing Council of reports on medical staff issues including temporary Hospital Medical Staff Privileges, Joint Commission Revisions for the 1992 Accreditation Manual for Hospitals; and Advance Directives;
- an information exchange on PRO Scope of Work and Uniform Clinical Data Sets: What You Should Know.

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HMSS

DOCTORS' NOTEBOOK

TRUSTEES' MINUTES

A regular meeting of the Board of Trustees was held on July 21, 1991, at the executive offices in Lawrenceville. Detailed minutes are on file with the secretary of your county society. A summary of significant actions follows.

President's Report.

1. HIV. Was informed that a special message was sent to New Jersey hospitals with the intention of developing and implementing a policy of HIV testing at hospitals.

2. Council of Medical Society Presidents. Noted that 16 of the 21 counties were represented at the Council meeting; Dr. Riggs provided an update of MSNJ activities, including the policy on HIV testing, current legislation, membership, and the resource-based relative value scale.

3. Medicine and the Media. Confirmed the workshop on communications on September 25, 1991, for those in county and state leadership positions.

4. Women Physicians. Heard that a program to encourage women physicians to join organized medicine and to assume leadership roles and responsibilities is being initiated.

5. Gender Bias in Medical Care. Noted that a news release will be issued by MSNJ in response to the *JAMA* report on gender bias in medical care; Dr. Riggs will ask physicians in the state to re-examine their practice patterns to assure full sexual equality.

6. International Medical School Graduates. Made mention of a recruitment program to increase the membership of physicians who are international medical graduates.

7. Practicing Physicians Initiative. Received an invitation from Doctor Richard C. Reynolds to discuss plans for a project under consideration by the UMDNJ Foundation concerning the role of private practitioners in the care of the uninsured and the under-insured and the reimbursement of physicians for that care.

8. Committee on Senior Citizens. Announced the members of the Committee: Doctors Ian D. Samson, Churchill L. Blakey, John P. Kohler, and A. Ralph Kristeller; topics to be considered include advance directives for health care, resource-based relative value scale, and senior courtesy programs.

9. Academy of Medicine. Encouraged members of the Board to join the Academy of Medicine of New Jersey.

10. Letter to Governor Florio. Noted that Dr. Riggs is in the process of writing to Governor Florio to suggest that the governor convene a meeting with physician leaders to hear their points of view regarding health care reform.

Report of the Executive Director.

1. MSNJ Membership. Received for its information a membership report as of June 28, 1991.

2. State Board of Medical Examiners (SBME). Noted the following: SBME will mail revised renewal application forms and that a reasonable response time would be allowed and that this entire case is scheduled for argument in the Appellate Division; litigation opposing authorization of physician assistants is expected to be argued in the Appellate Division at the end of the summer; and MSNJ filed an amicus brief on Doctor Sinha's behalf, in the case involving an anesthesiologist whose license was suspended by SBME for failure to provide supervision in a given situation.

3. Legal Defense Contribution. Assured county societies that they will have representation available at reasonable expense, provided MSNJ is notified in advance.

4. State Legislation. Noted the following: health care reform act was signed into law on July 1, 1991; MSNJ continues to oppose the legislation that would establish a separate board for the registration of physician assistants, and voted to call a special session of the House of Delegates on September 15, 1991, to reconsider MSNJ's position on physician assistants; MSNJ continues to oppose S-3491 and A-4585 that would grant prescriptive powers to nurse practitioners and nurse midwives; the optometric drug bill, A-743, that would authorize optometrists to diagnose disease and prescribe drugs is scheduled for another vote in the fall; and A-4367, concerning mandatory assignment, might come up for a vote before the Assembly Appropriations Committee on August 1.

AMA Annual Meeting. Noted the following from Dr. Karl T. Franzoni, chairman of the AMA Delegation: the two New Jersey resolutions (Medicare Notification of Payment and Medicare Home Health Services) were reaffirmed as existing AMA policy; adoption of policies by the AMA to strengthen its advocacy efforts and maintain AMA's leadership role in payment reform; the physician grassroots campaign to express strong objections to the proposed Medicare conversion factor cuts proposed by the

Health Care Financing Administration; important policy positions regarding routine HIV testing, and testing for health care workers, patients, and prisoners were adopted by the AMA; and received the state award for the AMA Outreach Program due to the exceptionally outstanding recruitment efforts of Doctors Angelo S. Agro, Robert A. Fuhrman, George T. Hare, Terry A. Johnston, Anthony C. Quartell, Craig B. Quigley, Thomas E. Simpson, Robert L. Wegryn, Robert J. Weierman, and Harold S. Yood.

UMDNJ Report. Received a report from Stanley S. Bergen, Jr, MD, concerning the following: UMDNJ support of MSNJ's efforts to make medical students aware of the potential role of MSNJ/AMA membership in the success of medical careers, and approval of the resolution on sustaining a cooperative working relationship between MSNJ and UMDNJ.

New Jersey Hospital Association. Received a report from Louis P. Scibetta concerning the following: support of a one-year extension for the uncompensated care trust fund; implementation of the Advance Directives for Health Care Act; general support of MSNJ's position on AIDS-related problems; and the unresolved issue concerning overcharging on Medicare/Medicaid for uncompensated care.

Academy of Medicine of New Jersey. Received a report from Gerald Shapiro, MD, concerning the following: annual awards dinner; and preparation of the *Annual Calendar* for 1991-1992.

Committee on Annual Meeting: Approved the following recommendations:

That the 226th Annual Meeting be held at the Trump Taj Mahal Casino/Resort in Atlantic City, New Jersey, on Sunday, May 3, through Wednesday, May 6, 1992.

That the Board of Trustees approve the proposed daily schedule for the 1992 Annual Meeting.

Committee on Young Physicians. Voted to postpone action on the following recommendation pending response from county medical societies:

That the Board of Trustees consider redefining the goals and structure of the Committee on Young Physicians.

Committee on Emergency Medical Care. Approved the following recommendation:

That the Medical Society disband the Committee on Emergency Medical Care and transfer its responsibilities to the Council on Public Health.

Council on Medical Services. Approved the following recommendation:

That the Board of Trustees consider redefining the structure of the Council on Medical Services due to the recent formation of diverse ad hoc committees.

Committee on Membership Services. Referred the following recommendation back to the Committee on Membership Services with a request that they develop a specific plan for consideration by the Board:

That the Medical Society consider establishing a formal legal assistance program for members.

Committee on Medical Aspects of Sports. Will refer the following recommendation back to the Committee on Medical Aspects of Sports for further study:

That the Board of Trustees promulgate the strong suggestion that physicians continue to be present at (high school) varsity football games and (high school) wrestling tournaments.

That if the State Athletic Trainers Association does not now keep statistics on injuries incurred during training, practice, and sporting events, they do so in the future as a resource for MSNJ.

Also, approved the following recommendation:

That MDs and DOs acting as school or team physicians develop a written understanding with school officials that defines their functions and responsibilities.

Committee on Membership Services. Approved the following recommendations:

That the Health Care Practice Management Service proposed by Button Associates [a health care management firm] be endorsed and offered as an additional service to the membership.

That MSNJ adopt the Preadmission Review and Mandatory Second Surgical Opinion Program offered by Blue Cross/Blue Shield of New Jersey proposed by Donald F. Smith & Associates.

That MSNJ request Blue Cross/Blue Shield to agree that the Mandatory Second Surgical Opinion Program permit patients to consult a physician of choice at the patient's expense. □

UMDNJ NOTES

Surgeon replaces diseased bladders. A surgeon at UMDNJ is the first in the state to construct a replacement bladder from a patient's own bowel. The procedure eliminates the need for an ostomy bag to hold urine, and it can even work on some men and women whose bladders have been removed in earlier surgery.

In the new procedure, Dr. Kenneth B. Cummings creates a replacement bladder from a portion of the patient's lower intestine and places it in the bladder's normal anatomical position. He then implants the ureters into the new bladder and the bladder is connected to the urethra. The replacement bladder, called the "Robert Wood Johnson pouch," is used in patients whose bladders have been surgically removed because of cancer. All patients who have received the new pouch are continent.

Dr. Cummings, one of a limited number of surgeons performing the procedure, is professor and chief of urology at UMDNJ-Robert Wood Johnson Medical School, New Brunswick.

Department of Family Medicine

created at Newark campus. A $500,000 federal grant has been awarded to UMDNJ-New Jersey Medical School to expand its newly created Department of Family Medicine. Dr. Mark S. Johnson, a 1979 graduate of the Newark medical school, has been appointed acting chairman of the new department. The Department of Health and Human Services grant will be used to develop curriculum and recruit faculty. With the creation of the new Department, UMDNJ now offers family medicine education at all three of its medical schools. The emphasis of the department will be on teaching medical students how to provide primary health care in an ambulatory setting. The new courses, aimed at first- and fourth-year medical students, will cover several aspects of primary ambulatory health care—from assessing psychosocial stressors to setting up a private practice.

Brain researcher finds clue to memory and learning. How do humans remember what they learn? How are momentary experiences translated into long-lasting memories? Is memory and learning affected by a chemical reaction in the brain?

Researchers at UMDNJ-Robert Wood Johnson Medical School offer significant new insight into the role a brain survival (trophic) hormone, called nerve growth factor (NGF), may play in memory and learning. The researchers have discovered that when a neuron receives an impulse or signal from another neuron, the receiving neuron turns on the NGF gene. The NGF hormone, in turn, is known to strengthen connections between neurons, allowing them to communicate more efficiently.

The research is being led by Dr. Ira Black, chairman of the school's Department of Neurosciences and Cell Biology and a widely known pioneer in NGF research.

Investigation focuses on juvenile fire setters. Most young fire setters suffer from disruptive behavior disorders and have experienced a recent stressful event, according to researchers at UMDNJ's Newark campus. But not all children with disruptive behavior problems set fires, prompting researchers to compare those juveniles who set fires with those youngsters who do not, in an effort to discover how to predict potential juvenile fire setters. The investigators are with the Division of Child and Adolescent Psychiatry at UMDNJ-New Jersey Medical School and UMDNJ-Community Mental Health Center.

The researchers hope learning to predict fire-setting behavior will help curtail a growing tide of fires started by juveniles. The research is funded by a $24,906 grant from the UMDNJ Foundation to Dr. Gabriel Kaplan, medical director of the mental health center's child psychiatry outpatient services.

Dr. Bergen elected to Board of American Hospital Association. The American Hospital Association (AHA)—an organization I have been associated with for more than two decades—has elected me to its Board of Trustees. The 25-member board has major policymaking authority for the association that represents most of the hospitals in the United States. Membership in the AHA comprises about 85 percent—approximately 5,500—of the country's hospitals. ☐ Stanley S. Bergen, Jr, MD

MSNJ AUXILIARY

Teamwork is a priority for 1991-1992. On the national level, the AMA Auxiliary and the AMA launched a three-step program to combat family violence. AMAA President Sherry Strebel urged states and counties across the nation to support the project focusing on educating the public, supporting victims, and providing physicians with resources for patients who are victims of family violence. In addition to the anti-violence campaign, the Auxiliary will work with the AMA to improve relations with the media, to increase donations to AMA-ERF, and to promote sound medical legislation.

In New Jersey, Auxiliary members joined Society members in responding to the severe threat to the Medicare payment reform by visiting legislators in Washington, DC, and by writing letters to senators, congressmen, and Health Care Finance Administration Administrator Gail Wilensky, PhD, expressing strong objections to the proposed cuts in the conversion factor for Medicare's new payment system, scheduled to go into effect in 1992. In addition, the Auxiliary assisted MSNJ by delivering "letter writing reminders" to physicians in hospitals throughout the state.

County auxiliaries also are working with their medical societies on a variety of health programs including eye and breast screenings. Joint efforts at fundraising are providing thousands of dollars for medical school scholarships, equipment for hospital pediatric wards and nursing homes, and financial assistance to needy families in which physicians have been called to serve in the armed forces. And finally, physicians and Auxiliary members are working together in the community on undertakings such as "Women's Health Awareness" in Camden County, "Adopt-A-Nursing Home" in Gloucester County, and career programs for inner-city children in Mercer County. ☐ Marion H. Geib

The Medical Society of New Jersey would like to welcome the following new members:

Atlantic County
Sarmad Aji, MD
Jonathan D. Gewirtz, MD
Richard C. Kovach, MD
John D. Lorenzetti, MD
Christopher J. Lucasti, DO
Allan R. Wentt, Jr, MD

Bergen County
Lorraine E. Driscoll, MD
Susan M. Ksiazek, MD
Martha J. Maso, MD
Morey J. Menacker, DO
Usha Setia, MD

Camden County
Collin E.M. Brathwaite, MD
Paul A. Curtis, MD
Jeffrey M. Finkelstein, MD
Eytan A. Irwin, MD
Anne C. Mack, MD
Carlos S. Madamba, MD
Felix A. Perez, MD
Edward M. Podgorski, Jr, MD
Gus J. Slotman, MD
George S. Taliadouros, MD
Richard L. Weiss, MD

Cape May County
Gene J. Braga, MD
Vijaykumar K. Gandhi, MD

Cumberland County
John A. DeLeonardis, MD
Richard J. Weiss, MD

Essex County
Selwyn J. Baptist, MD
Katherine B. Benevenia, MD
Joaquim J. Correia, MD
Donald J. Felitto, MD
Alan J. Goodman, MD
Bruce H. Greene, DO
Jonathan F. Lara, MD
Kevin J. McCoach, MD
Joel Meer, MD
Stephen U. Solomon, MD

Gloucester County
Mark S. Andrew, MD

Hudson County
Gary R. Spiegel, MD

Mercer County
Joyce G. Afran, MD
Francis X. Burke, III, MD
Shari E. Diamond, DO
Frances J. Dunston, MD
H. Charles Fishman, MD
Michal P. Gerwel, MD
Michael S. Grenis, MD
Gary S. Karlin, MD
Josef J. Vanek, MD
Dhanlakshmi Venkataraman, MD

Middlesex County
Scott D. Schlesinger, MD
Donna M. Timchak, MD

MEETINGS OF THE BOARD OF TRUSTEES of the Medical Society of New Jersey

October 20, 1991
November 17, 1991
December 15, 1991
January 19, 1992
February 9, 1992
March 15, 1992
April 15, 1992

Meetings of the Board of Trustees are open to all physicians. The meeting on March 15, 1992, is an OPEN FORUM, to allow physicians the opportunity to stand up and be heard. If you would like to attend the OPEN FORUM, please contact Diana Gore, MSNJ headquarters, 609/896-1766.

ARE YOU MOVING?

If so, please send a change of address to *NEW JERSEY MEDICINE*, Medical Society of New Jersey, Two Princess Road, Lawrenceville, NJ 08648, at least six weeks before you move.

Name _____

Old Address _____

City _____ State _____ Zip _____

New Address _____

City _____ State _____ Zip _____

Monmouth County
Abdul N. Ani, MD
Eugene F. Cheslock, MD
Dionisio V. Cruz, MD
Hector R. Iglesias, MD
Lester D. Simon, MD
Ira M. Strauss, MD
Erica Weinstein, MD

Morris County
Laila M. Almeida, MD
Vincent Cubelli, MD
Timothy E. Fitzgerald, MD
Steven Goldstein, MD
Larry L. Hipp, MD
Carl B. Wallach, MD

Ocean County
Luzminda M. Anama, MD
Julian Auerbach, MD
Michael Bageac, MD
Pedro P. Gonzalez, MD
Ali R. Moosvi, MD

Passaic County
Robert J. Cusumano, MD

Somerset County
Ronald M. Frank, MD
Daisy A. Rodriguez, MD

Union County
Henry M. Altszuler, MD
Carol Ann B. McHugh, MD
Maureen P. Whalen, MD

PLACEMENT FILE

The following physicians have written to the executive offices of MSNJ seeking information on opportunities for practice in New Jersey. If you are interested in information concerning these physicians, we suggest you make inquiries directly to them.

Cardiology

George D. Birmingham, MD, 3531 Salerno Ct., Apt. 5, Middleton, WI 53562. Mount Sinai 1984. Board eligible. Board certified (IM). Group or partnership. Available.

Family Medicine

Vicente F. Franco, MD, 9362 Bay Colony Dr., Apt. 1S, Des Plaines, IL 60016. Universidad Central del Este 1982. Board eligible. Available.

Internal Medicine

Thomas P. Hooker, DO, 2804 Sitios St., Tampa, FL 33629. Philadelphia College of Osteopathic Medicine 1984. Board certified; also, PUL. Solo or multispecialty group. Available.

Marc Kesselhaut, MD, 1 Rustic Ridge, C16, Little Falls, NJ 07424. St. George's University 1986. Board eligible. Solo or partnership in Mercer, Somerset, Burlington, Hunterdon, or Middlesex counties. Available.

M. Stekelman, MD, P.O. Box 900, Hightstown, NJ 08520. BSAS (Argentina) 1959. Also, gastroenterology. Board eligible. Outpatient or ambulatory facility. Available.

Nephrology

Vinitha Raj, MD, 82-30 26th St., Floral Park, NY 11204. Guntar Medical School (India) 1981. Board eligible. Board certified (IM). Group or partnership.

Obstetrics/Gynecology

Dennis Tumbokonm, MD, P.O. Box 476, Kimball, WV 24853. University of the East. Board eligible. Solo. Available.

Pediatrics

Donna Churlin, MD, 55 Montgomery St., Bloomfield, NJ 07003. UMDNJ 1987. Board eligible. Partnership or group in central New Jersey (Essex, Union, or Morris counties). Available.

Radiation Oncology

Carol L. Kornmehl, MD, 133 Wyncrest Rd., Marlboro, NJ 07746. SUNY-Downstate 1984. Board certified. Group, partnership, solo. Available.

Surgery

Nichlas J. Dudas, MD, 915 Princeton Ave., Philadelphia, PA 19111. UMDNJ 1986. Board eligible. Group or partnership. Available.

ERRATA

We would like to make the following correction: Paul W. Armstrong, Esq., is chairman of the New Jersey Commission on Legal and Ethical Problems in the Delivery of Health Care, and Robert L. Pickens, MD, is chairman of the Medical Society of New Jersey Committee on Biomedical Ethics. □

PHILADELPHIA HEART INSTITUTE

at Presbyterian Medical Center

Cardiology Update

designed for the physician and provides an intensive survey of the current status of clinical cardiology . . .

Wednesday, November 6, 1991

The Electrocardiogram: Old and New Concepts

Moderator: Leonard N. Horowitz, M.D.

3:00-3:30 Normal and abnormal electrocardiographic findings: Abnormal tracings from normal subjects will also be used—***Steven J. Nierenberg, M.D.***

3:30-4:00 Common pitfalls in diagnosing cardiac arrhythmias and conduction problems: Transtelephonic recordings will be used—***Leonard N. Horowitz, M.D.***

- *Case Presentations and Panel Discussions*
- *CME Credits**
- *No Registration Fee*
- *Call for Reservations 215-662-8627*

Scheie Auditorium

Presbyterian Medical Center
39th & Market Streets
Philadelphia, Pennsylvania 19104

The Philadelphia Heart Institute at Presbyterian Medical Center is an affiliate of the University of Pennsylvania.

**Presbyterian Medical Center designates this continued medical education activity for 2 credit hours in Category I of the Physicians' Recognition Award of the American Medical Association and the Pennsylvania Medical Society Membership requirement. Nine sessions, 18 credits.*

CONTINUING EDUCATION

INFECTIOUS DISEASE

November

1, 8, 15, 22, 29 **Inter-Jersey Infectious Disease Rounds**
Hackensack Medical Center, Newark Beth Israel Medical Center, St. Joseph's Hospital and Medical Center, Overlook Hospital, and University Hospital
(UMDNJ and AMNJ)

19 **AIDS Training and Resource Program for Hospital Health Educators**
1-2 P.M.—New Lisbon Developmental Center, New Lisbon
(AMNJ and NJDOH)

20 **Identification and Management of Asymptomatic HIV-Infection**
9-10 A.M.—Warren Hospital, Phillipsburg
(AMNJ and NJDOH)

December

6, 13, 20, 27 **Inter-Jersey Infectious Disease Rounds**
Hackensack Medical Center, Newark Beth Israel Medical Center, St. Joseph's Hospital and Medical Center, Overlook Hospital, and University Hospital
(UMDNJ and AMNJ)

9 **Chronic Epstein-Barr Virus**
1-2 P.M.—New Lisbon Developmental Center, New Lisbon
(AMNJ and NJDOH)

12 **Identification and Management of Asymptomatic HIV-Infection**
1-2 P.M.—James J. Howard VA Outpatient Clinic, Brick
(AMNJ and NJDOH)

18 **Identification and Management of Asymptomatic HIV Infection**
8-9 A.M.—Barnert Hospital, Paterson
(AMNJ and NJDOH)

MEDICINE

November

5 **Followup on Intervention To Reduce C-Section Rates**
12:15-1:30 P.M.—John Fitch Plaza, Trenton
(AMNJ and NJDOH)

6, 13, 20, 27 **Endocrinology Monthly Meeting**
6-9 P.M.—Holiday Inn, Newark Airport, Newark
(AMNJ)

6, 13, 20, 27 **Endocrinology Grand Rounds**
11:30 A.M.-1 P.M.—VA Medical Center, East Orange
(AMNJ)

6, 13, 20, 27 **Dermatology Grand Rounds**
6-9 P.M.—Rutgers Community Health Plan, New Brunswick
(UMDNJ)

6, 13 **Interhospital Endocrine Rounds**
3:30-5:30 P.M.—Newark Beth Israel Medical Center, University Hospital, VA Medical Center, and United Hospitals Medical Center
(AMNJ)

6 **Prostatic Enlargement in the Elderly Male**
10:30-11:30 A.M.—St. Mary's Hospital, Passaic

7 **Multiple Sclerosis: Treatment Approaches**
6-9 P.M.—Welkind Rehabilitation Hospital, Chester
(Welkind Rehabilitation Hospital)

7 **Appropriate Fluid IV Ordering, Electrolyte and Fluid Balance, TPN**
12 Noon-1 P.M.—Community Medical Center, Toms River
(Community Medical Center)

11 **Diabetic Nephropathy**
7-8 P.M.—Wallkill Valley General Hospital, Sussex
(AMNJ and NJDOH)

12 **Dermatology Monthly Meeting**
7 P.M.—Schering Corporation, Kenilworth
(Dermatological Society of New Jersey and AMNJ)

12 **Molecular Genetics**
7-8 P.M.—Shore Memorial Hospital, Somers Point
(AMNJ)

13 **Resource-Based Relative Value Scale**
All day—MSNJ Headquarters, Lawrenceville
(MSNJ)

13 **Fall Scientific Meeting and Dinner: Thoracic Outlet Syndrome**
6 P.M.—The Manor, West Orange
(Vascular Society of NJ)

13 **Diabetic Nephropathy**
1-2 P.M.—VA Medical Center, Lyons
(AMNJ and NJDOH)

13 **Autologous Blood Transfusion**
10:30-11:30 A.M.—St. Mary's Hospital, Passaic
(AMNJ)

14 **Diabetes-Related Cardiovascular Disease**
1-2 P.M.—James J. Howard VA Outpatient Clinic, Brick
(AMNJ and NJDOH)

14-17 **Upper Extremity Prosthetics and Orthotics**
8 A.M.-5 P.M.—Kessler Institute, West Orange
(Kessler Institute)

19 **General Membership Meeting**
All day—Ramada Inn, Clark
(NJ State Society of Anesthesiologists)

20 **Immunizations**
10:30-11:30 A.M.—St. Mary's Hospital, Passaic
(AMNJ)

20 **Dermatology Conference**
6-9 P.M.—Rutgers Community Health Plan, New Brunswick
(UMDNJ)

December

3 **Hepatatis B and C**
12:15-1:30 P.M.—John Fitch Plaza, Trenton
(AMNJ and NJDOH)

Hahnemann University

Department of Medicine Grand Rounds
Wednesdays 8:30 a.m.-9:30 a.m.
Oct.-Dec. 1991

October 1991

October 2, 1991

NSAIDS: MECHANISMS OF ACTION AND ADVERSE REACTIONS
William M. O'Brien, M.D.
Professor of Medicine
Division of Rheumatology
University of Virginia
Charlottesville, VA

October 9, 1991

GENE ACTIVATION AND CYTOKINES IN PULMONARY INFLAMMATION & FIBROSIS
John A. McDonald, M.D.
Professor of Medicine, Biochemistry and Molecular Biology
Mayo Medical School
Director of Research
Mayo Clinic, Scottsdale
Scottsdale, AZ

October 16, 1991

CARDIAC ELECTROPHYSIOLOGY AND IMAGING
Scott E. Hessen, M.D.
Assistant Professor of Medicine
Division of Cardiology, Hahnemann University
Charles C. Nydegger, M.D.
Assistant Professor of Medicine
Division of Cardiology, Hahnemann University
Steven P. Kutalek, M.D.
Assistant Professor of Medicine
Director, Clinical Cardiac Electrophysiology
Division of Cardiology, Hahnemann University

October 23, 1991

HLA-B27—PAST, PRESENT AND FUTURE
James Louie, M.D.
Professor of Medicine
Chief, Division of Rheumatology
Department of Medicine
Harbour-UCLA Medical Center
Torrence, CA

October 30, 1991

MANAGEMENT AND PREVENTION OF ANAPHYLACTOID REACTIONS FROM RADIOCONTRAST MEDIA
David M. Lang, M.D.
Assistant Professor of Medicine
Division of Allergy, Critical Care and Pulmonary Medicine
Hahnemann University

November 1991

November 6, 1991

TREATMENT OF HYPERLIPIDEMIA
David Bilheimer, M.D.
Professor of Medicine
University of Texas
Southwest Medical Center
Dallas, Texas

November 13, 1991

DIAGNOSIS AND TREATMENT OF BREAST CANCER
Isadore Brodsky, M.D.
Professor and Chairman
Department of Neoplastic Diseases
Hahnemann University
S. Benham Kahn, M.D.
Professor of Neoplastic Diseases
Department of Neoplastic Diseases
Hahnemann University

November 20, 1991

TREATMENT OF OSTEOPOROSIS
Robert Lindsay, M.D., Ph.D.
Professor of Clinical Medicine
Columbia University College of Physicians and Surgeons
Chief, Internal Medicine
Helen Hayes Hospital, NY

November 27, 1991

AIDS AND CARDIOVASCULAR COMPLICATIONS OF SUBSTANCE ABUSE
Vincent Zarro, M.D., Ph.D.
Professor of Medicine
Director, Division of Clinical Pharmacology
Hahnemann University

December 1991

December 4, 1991

DIASTOLIC MECHANISMS OF HEART FAILURE
Robert O. Bonow, M.D.
Chief, Nuclear Cardiology
Deputy Chief, Cardiology Branch
NHLBI, Bethesda, MD

December 11, 1991

THYROTOXICOSIS: A SPECTRUM OF DISEASE
Lewis E. Braverman, M.D.
Professor of Medicine and Physiology
Director, Division of Endocrinology
University of Massachusetts

December 18, 1991

IMMUNOLOGY AND RHEUMATOLOGY CLINICAL RESEARCH
Lawrence H. Brent, M.D.
Assistant Professor of Medicine
Division of Immunology and Rheumatology,
Hahnemann University
Carolyn H. McGrory, R.N., M.S.
Clinical Nurse Specialist
Division of Immunology and Rheumatology,
Hahnemann University

December 25, 1991

No Grand Rounds

Hahnemann University Department of Medicine Wednesday Medical Seminar Series 8:30 a.m.-3:30 p.m.

October 9, 1991
PULMONARY DISORDERS OF INFLAMMATION AND FIBROSIS

November 6, 1991
TREATMENT OF HYPERLIPIDEMIA

November 13, 1991
DIAGNOSIS AND TREATMENT OF BREAST CANCER

November 20, 1991
TREATMENT OF OSTEOPOROSIS AND METAGOLIC BONE DISEASE

Seminar Directors:

William S. Frankl, M.D.
Professor of Medicine and Chairman
Department of Medicine

Allan B. Schwartz, M.D.
Professor of Medicine
Director, Continuing Medical Education for the Department of Medicine

Location:

Classroom C (Alumni Hall)
2nd Floor New College Building
Hahnemann University 15th Street Entrance
15th & Vine Streets
Philadelphia, PA

As an organization accredited by the Accreditation Council for Continuing Medical Education (ACCME), Hahnemann University designates this continuing medical education activity as Category 1 of the Physician's Recognition Award of the American Medical Association. One credit hour may be claimed for each hour of participation by the individual physician.

For information, call the Office of Continuing Education at (215) 448-8263

4 **Ophthalmology Meeting**
All day—Ocean Place Hilton, Long Branch
(NJ Academy of Ophthalmology and Otolaryngology)

4 **Endocrinology Monthly Meeting**
6-9 P.M.—Holiday Inn, Newark Airport, Newark
(AMNJ)

4 **Endocrinology Grand Rounds**
11 11:30 A.M.-1 P.M.—VA Medical
18 Center, East Orange
(AMNJ)

4 **Interhospital Endocrine**
11 **Rounds**
18 3:30-5:30 P.M.—Newark Beth Israel Medical Center, University Hospital, VA Medical Center, and United Hospitals Medical Center
(AMNJ)

4 **Prevention of Lower Extremity Amputations**
9-10 A.M.—Warren Hospital, Phillipsburg
(AMNJ and NJDOH)

4 **JCAH Standards**
10:30-11:30 A.M.—St. Mary's Hospital, Passaic
(AMNJ)

4 **Meeting: New Jersey Society of Physical Medicine and Rehabilitation**
6:30 P.M.—St. Lawrence Rehabilitation Center, Lawrenceville
(NJ Society of Physical Medicine and Rehabilitation)

5 **Appropriate Fluid IV Ordering, Electrolyte and Fluid Balance, TPN**
12 Noon-1 P.M.—Community Medical Center, Toms River
(Community Medical Center)

6- **Pediatric Life Support**
7 All day—Shore Memorial Hospital, Somers Point
(Shore Memorial Hospital and AMNJ)

7 **8th Annual Clinical Update in Pulmonary Medicine**
8 A.M.-5 P.M.—Caesar's Hotel and Conference Center, Atlantic City
(Deborah Heart and Lung Center)

10 **Risk Factors for Oral Cancer**
12:15-1:30 P.M.—John Fitch Plaza, Trenton
(AMNJ and NJDOH)

11 **Diabetic Retinopathy**
1-2 P.M.—VA Medical Center, Lyons
(AMNJ and NJDOH)

11 **Estrogen Replacement Therapy**
10:30-11:30 A.M.—St. Mary's Hospital, Passaic
(AMNJ)

18 **Pulmonary Grand Rounds**
11:30 A.M.-12:30 P.M.—Newcomb Medical Center,

ONCOLOGY & RADIATION ONCOLOGY

November

21 **Tumor Board Conference**
12:15-1:15 P.M.—Mercer Medical Center, Trenton
(Mercer Medical Center)

27 **Cocktail Reception**
6:30-9 P.M.—The Manor, West Orange
(Radiation Oncology Section, AMNJ)

December

11 **13th Tumor Board Conference**
6 P.M.—MSNJ Headquarters, Lawrenceville
(Oncology Society of New Jersey)

19 **Cocktail Reception**
6:30-9 P.M.—Hyatt Regency, Route 27, New Brunswick
(Head and Neck Oncology Section, AMNJ)

19 **Tumor Board Conference**
12:15-1:15 P.M.—Mercer Medical Center, Trenton
(Mercer Medical Center)

PSYCHIATRY

November

5 **Patient's Fear of Becoming a Patient**
8:30-10 A.M.—Elizabeth General Medical Center
(Elizabeth General Medical Center)

7 **Neurobiology of Drug Abusers**
12 Noon-1 P.M.—Carrier Foundation, Belle Mead
(Carrier Foundation)

12 **Conflict Over Child Custody**
8:30-10 A.M.—Elizabeth General Medical Center, Elizabeth
(Elizabeth General Medical Center)

13 **Mental Health and the Law**
All day—Carrier Foundation, Belle Mead
(Carrier Foundation)

14 **Scientific Meeting**
8-10 P.M.—Hackensack Medical Center, Hackensack
(NJ Psychoanalytic Society)

14 **Pharmacotherapy of Dysthymia**
12 Noon-1 P.M.—Carrier Foundation, Belle Mead
(Carrier Foundation)

21 **Electroconvulsive Therapy**
12 Noon-1 P.M.—Carrier Foundation, Belle Mead
(Carrier Foundation)

27 **Obsessive Compulsive Disorder: Diagnosis, Comorbidity, and Treatment**
1:30-2:30 P.M.—Trenton Psychiatric Hospital, Trenton
(Trenton Psychiatric Hospital and AMNJ)

December

5 **Community Meeting as Large Group Psychotherapy**
12 Noon-1 P.M.—Carrier Foundation, Belle Mead
(Carrier Foundation)

12 **Medicolegal and Ethical Aspects of Prescribing Psychotropics**
12 Noon-1 P.M.—Carrier Foundation, Belle Mead
(Carrier Foundation)

13 **Geriatric Psychopharmacology**
10-11 A.M.—Marlboro Psychiatric Hospital, Marlboro
(AMNJ)

19 **Outpatient Behavioral Therapy with Adolescents**
12 Noon-1 P.M.—Carrier Foundation, Belle Mead
(Carrier Foundation)

THE NEW JERSEY HOSPITAL ASSOCIATION
HEALTH RESEARCH AND EDUCATIONAL TRUST OF NJ
and
MEDICAL SOCIETY OF NJ
Present

"PREPARING FOR RBRVS: A SEMINAR FOR PHYSICIANS AND HOSPITALS"

November 13, 1991
9:00-2:15
at
Medical Society of NJ
2 Princess Lane
Lawrenceville, NJ

Topics include: Principles of RBRVS, How to Maximize Opportunities Under RBRVS, and Implications for Healthcare

For registration information please call: (609) 275-4115

Acupuncture & Electro-Therapeutics in Clinical Practice

New York State Boards of Medicine & Dentistry 25-hour accredited seminar & workshop on latest theories & techniques of manual & electro-acupuncture, TENS & simple non-invasive diagnostic methods (including cardio-vascular, neuromuscular, central nervous systems & "Bi-Digital O-Ring Test"), applicable towards 300-hour requirement for certification to practice acupuncture, will be given periodically for licensed clinicians (with or without prior training) on 3-day weekends (Fri-Sun) of Nov. 22-24, and Dec. 13-15, 1991, at Milford Plaza Hotel, 45th St. & 8th Ave., New York City.

The 7th Annual International Symposium on Acupuncture & Electro-Therapeutics will be held at Columbia University, School of International Affairs, 420 W. 118th St., N.Y. City, during October 17-20, 1991.

These meetings are co-sponsored by the International College of Acupuncture & Electro-Therapeutics & its official journal, Acupuncture & Electro-Therapeutics Research, The International Journal (published by Pergamon Press & indexed in 15 major indexing periodicals, including Index Medicus), Heart Disease Research Foundation; NY Pain Center; Electrical Engineering Dept., Manhattan College; Nordic Medical Acupuncture Society (Scandinavia); Schmerz Therapeutische Kolloquium (West Germany); Japan Bi-Digital O-Ring Test Assn.; Accredited toward Acupuncture Certification to practice acupuncture. Eligible for AMA CME Cat. I credit (about 40 credit-hours for the Symposium).

For information on meetings or submission or presentations of papers, contact Symposium Chairman, Prof. Y. Omura, M.D., Sc.D., 800 Riverside Drive (8-I) New York, NY 10032 Tel: (212) 781-6262 (10 am to 10 pm 7 days a week) or (212) 928-0658, Co-chairman, Prof. A.W. Cook, MD (516) 877-1821, or Bro. Michael Losco (212) 920-0162.

DEBORAH HEART AND LUNG CENTER

DEPARTMENT OF PULMONARY MEDICINE

PRESENTS

EIGHTH ANNUAL CLINICAL UPDATE IN PULMONARY MEDICINE

Saturday, December 7, 1991
Caesars Atlantic City
Atlantic City, New Jersey

Designed for Family Practitioners, Internists, Pulmonologists, and Allied Health Care Professionals

8 Hours Category 1 CME Credit
Spouse Program/Optional Activities

PROGRAM

Acute Pulmonary Embolism ..... Roger Bone, MD

Radiology of the Pneumoconioses ..... William K.C. Morgan, MD

The Clara Falk Franks Lecture - Respiratory Failure and Multi-organ Failure: New Concepts ..... Roger Bone, MD

Asbestosis and Asbestos-Related Pleural Disease ..... William K.C. Morgan, MD

Hypersensitivity Pneumonitis ..... David Murphy, MD

Acute Respiratory Failure in Chronic Obstructive Pulmonary Disease ..... Thomas Petty, MD

Community Acquired Pneumonia-1991 ..... John Bartlett, MD

Newer Approaches to Asthma Management ..... Thomas Petty, MD

Opportunistic and Nosocomial Pulmonary Infections ..... John Bartlett, MD

Drug-Induced Lung Disease: A Microcosm of Pulmonary Medicine ..... Mervyn Feierstein, MD

For information contact :
Center for Bio-Medical Communication, Inc.
80 West Madison Avenue, Dumont, NJ 07628 (201) 385-8080

RADIOLOGY

November

14 **MRI Conference and Case Presentation**
7:30-9:30 P.M.—Saint Barnabas Medical Center, Livingston
(NJ Institute of Ultrasound in Medicine, Radiological Society of New Jersey, and Diagnostic Radiology Section, AMNJ)

28 **Radiology Lecture**
1:30-5 P.M.—Saint Barnabas Medical Center, Livingston
(Saint Barnabas Medical Center)

December

12 **MRI Conference and Case Presentation**
7:30-9:30 P.M.—Saint Barnabas Medical Center, Livingston
(NJ Institute of Ultrasound in Medicine, Radiological Society of New Jersey and Diagnostic Radiology Section, AMNJ)

19 **Radiology Lecture**
1:30-5 P.M.—Saint Barnabas Medical Center, Livingston
(Saint Barnabas Medical Center)

HIV CONFERENCE

A conference entitled, "Testing for HIV: Why, Who, When, Where," will be held on October 30, 1991, at the Medical Society of New Jersey. The program is sponsored by the Medical Society of New Jersey, New Jersey Hospital Association, Academy of Medicine of New Jersey, Health Research and Educational Trust of New Jersey. Registration is limited. The program is as follows:

8:30 A.M.—Registration.

9:00 A.M.—Welcome: Joseph A. Riggs, MD, President, MSNJ.

9:15 A.M.—Perspectives on Universal HIV Testing: Gabriel Sciallis, MD, and Jeffrey Frerichs.

10:15 A.M.—HIV Testing and the Responsibilities of Health Professionals: Nancy Dickey, MD.

11:00 A.M.—The Science of HIV Testing: Thomas E. England, PhD.

11:30 A.M.—Hospital Perspective: Marc Lory.

12:00 NOON—Luncheon.

12:30 P.M.—Developing an HIV Testing Policy: Paul Armstrong, MA, JD, LLM.

1:00 P.M.—Occupational Exposure to HIV: Richard Dixon, MD.

1:30 P.M.—Panel Discussion.

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IN MEMORIAM

RICHARD B. BERLIN, SR

Teaneck resident, Richard Barnard Berlin, Sr, MD, died on April 1, 1991, at the age of 73. Born in Chicago, Illinois, on March 31, 1918, Dr. Berlin was awarded a medical degree from the University of Chicago, The Pritzker School of Medicine, Illinois, in 1942. He received his New Jersey medical license in 1952. Dr. Berlin was on staff at Englewood Hospital for 40 years; he was an assistant surgeon at Flower & Fifth Avenue Hospital, New York. Working from his basement, Dr. Berlin invented four patented medical devices, including clamps that aid surgical precision. Dr. Berlin was an instructor in surgery at New York Medical College, New York. Dr. Berlin was past-president of our Bergen County component and a member of the American Medical Association. He was a diplomate of the American Board of Pathology and of the American Board of Surgeons, and a fellow of the American College of Surgeons. He was a Teaneck health officer and a trustee of the Bergen County Blood Bank. Dr. Berlin was a general surgeon and an oncologist. During World War II, Dr. Berlin served in the United States Navy.

VITO F. CANGEMI

Retired for 14 years, Vito Frances Cangemi, MD, died on June 1, 1991. Dr. Cangemi practiced in Summit and Jersey City, and resided in Elizabeth and Jersey City before retiring to Massachusetts. Born on September 12, 1911, Dr. Cangemi earned his medical degree from Georgetown University School of Medicine, Washington, DC, in 1936, and received his New Jersey medical license the following year. An internist, Dr. Cangemi was director of the Jersey City Medical Center; he was affiliated with St. Francis Hospital, Jersey City, and was an instructor at UMDNJ-Newark. Dr. Cangemi was a member of our Hudson County component and of the American Medical Association; a fellow of the American College of Physicians; and a diplomate of the American Board of Internal Medicine.

ELIZABETH CONOVER

A member of our Union County component, Elizabeth Conover, MD, died on January 2, 1989. Dr. Conover was born in Greenwich, Connecticut, on August 30, 1916. Dr. Conover earned a medical degree from Cornell University Medical College, New York, in 1941. After completing an internship at Albany Medical Center Hospital, New York, and a residency at Columbia-Presbyterian Medical Center, New York, Dr. Conover received her New Jersey medical license in 1944. An anesthesiologist, Dr. Conover practiced in Summit and resided in Berkeley Heights. Dr. Conover was a member of the American Medical Association.

CHARLES A. CRANDELL

At the grand age of 90, Charles Archie Crandell, MD, passed away on April 7, 1991. Dr. Crandell was born in Cleveland,

Ohio, on October 5, 1900. He earned a medical degree from Hahnemann Medical College, Philadelphia, in 1927. In 1930, Dr. Crandell received his New Jersey medical license. Specializing in psychiatry, Dr. Crandell practiced at New Jersey State Hospital, Greystone Park; he also served as a hospital administrator. Dr. Crandell was past-president of our Morris County component, of the New Jersey District Branch of the American Psychiatric Association, and of the New Jersey Neuropsychiatric Association. Dr. Crandell was a member of the American Medical Association; a fellow of the American College of Physicians and of the American Association for the Advancement of Science; and a diplomate of the American Board of Neurology. For his 50 years of service, Dr. Crandell was honored with the MSNJ Golden Merit Award. During World War II, Dr. Crandell served in the United States Air Force at various hospitals. Dr. Crandell retired 20 years ago to Swarthmore, Pennsylvania.

ANTON CZIRAKY

At the grand age of 81, Anton Cziraky, MD, passed away on June 25, 1991. He was born in New York City on July 21, 1909. Dr. Cziraky attended the University of Vienna School of Medicine, earning his medical degree in 1936. Dr. Cziraky received his New Jersey medical license in 1945. During his lengthy career as a general practitioner, Dr. Cziraky practiced in Union City and was affiliated with North Hudson Hospital, Weehawken, and Jersey City Medical Center. Dr. Cziraky was a member of the American Medical Association and of our Hudson County component. Dr. Cziraky served in the United States Army during World War II. Dr. Cziraky resided in North Bergen and Fort Lee.

JOSEPH M. DELUCA

Joseph Mario DeLuca, MD, died on May 18, 1991, at the age of 77. Dr. DeLuca was born in Italy on November 20, 1913; he earned his medical degree from Hahnemann Medical College, Philadelphia, in 1941, and received his New Jersey medical license one year later. A general surgeon, Dr. DeLuca maintained a practice in Camden County and was attending at Our Lady of Lourdes Hospital, Camden, and a consultant at Ancora Psychiatric Hospital, Winslow Township, and at William B. Kessler Memorial Hospital, Hammonton. Dr. DeLuca served as a captain in the United States Army during World War II. He was a member of our Camden County component and of the American Medical Association; a diplomate of the American Board of Surgeons; and a fellow of the American College of Surgeons. Dr. DeLuca resided in Camden and Merchantville.

ALDEAN S. INGRAM

Retired since 1989, Aldean Starr Ingram, MD, of Westfield, died on May 30, 1991, at the age of 82. Born in Indian Springs, Georgia, on November 2, 1908, Dr. Ingram attended Emory University, School of Medicine, Atlanta, Georgia, earning his medical degree in 1936. After completing a residency and an internship at Grady Memorial Hospital, Atlanta, Georgia, Dr. Ingram served in the United States Army from 1941 to 1946. Then he completed a residency in 1948 at Doctor's Hospital, New York. He received his New Jersey medical license in 1950. Dr. Ingram specialized in obstetrics, gynecology, and family planning. Dr. Ingram worked for the Farm Security Administration and the Georgia Department of Health, managing rural public health

projects for the state of Georgia. He practiced in Westfield for many years serving as chief of obstetrics and gynecology at Overlook Hospital, Summit. Dr. Ingram was a member of our Union County component, of the Westfield Medical Society, and of the American Medical Association; a fellow of the American College of Obstetricians and Gynecologists; and a diplomate of the American Board of Obstetrics and Gynecology.

KENNETH H. JUDY

General surgeon, Kenneth Henry Judy, MD, died on June 20, 1991, at the age of 83. Dr. Judy was born in Denmark, Iowa, on February 26, 1908; he was awarded his medical degree from the University of Iowa School of Medicine, in 1933, and earned an advanced degree in surgery from McGill University, Montreal, Canada, in 1938. Dr. Judy received his New Jersey medical license in 1940. Dr. Judy practiced in Jersey City, and was affiliated with Bayonne Hospital; North Hudson Hospital; St. Mary Hospital; Margaret Hague Maternity Hospital; St. Francis Medical Center; Jersey City Medical Center; Christ Hospital; Greenville Hospital; and East Orange Veterans Administration Medical Center. Dr. Judy was a fellow of the American College of Gastroenterology, of the American College of Surgeons, and of the International College of Surgeons; a member of the American Medical Association, of our Hudson County component, of the New Jersey Diabetic Association, and of the New Jersey Surgical Society; and a diplomate of the American Board of Surgeons. Dr. Judy resided in Jersey City; Weehawken; and New Hope, Pennsylvania. During his lengthy military career, Dr. Judy served in World War II and the Korean conflict. He was awarded the Congressional Medal of Honor for his efforts during World War II. Dr. Judy was the oldest living active surgeon in the Army Reserves.

JANE W. KIENLE

Psychiatrist Jane Witmer Kienle, MD, passed away on June 6, 1991. Dr. Kienle was born on December 11, 1922, in Hanover, Pennsylvania; she was awarded a medical degree from Albany Medical College, Albany, New York, in 1948. Dr. Kienle completed an internship at Hahnemann Hospital and a residency at Eastern Pennsylvania Psychiatric Institute, both in Philadelphia. Dr. Kienle received her Pennsylvania, Ohio, and New Jersey medical licenses in 1949, 1956, and 1957, respectively. She was a member of our Camden County component, of the Philadelphia and Ohio medical societies, and of the American Medical Association. Dr. Kienle maintained a practice in Haddonfield and was affiliated with West Jersey Hospital, Camden. Dr. Kienle resided in Medford for the last 30 years.

CHESTER J. MODESKI

Anesthesiologist Chester Joseph Modeski, MD, passed away on May 7, 1991, at the age of 76. Dr. Modeski was born on December 12, 1914, in Newark. He attended Boston University School of Medicine, Massachusetts, earning his medical degree in 1939. Dr. Modeski received his New Jersey medical license in 1941. Dr. Modeski practiced in Short Hills and was affiliated with Saint Barnabas Medical Center, Livingston; St. Michael's Medical Center, Newark; and Presbyterian Hospital, Newark. He was a member of our Essex County component and of the American Medical Association. He was a fellow of the American College of Anesthesiologists.

EDITORIAL CRITERIA

CONTENT

NEW JERSEY MEDICINE is the official organ of the Medical Society of New Jersey. The goals are educational and informational. All material published is copyrighted by the Medical Society of New Jersey.

The educational contents of each issue appear as scientific articles, based on research, original concepts relative to epidemiology of disease, and treatment methodology; case reports; review articles; clinical notes; state of the art reports; and special articles, that include evaluations, policy and position papers, and reviews of nonscientific subjects. Other topics include professional liability commentary; critical narration; medical history; pediatric briefs; nutrition update; and opinions. Editorials are prepared by the editor and by guest contributors on timely and relevant subjects. The Doctors' Notebook section contains organizational and administrative items from the Medical Society of New Jersey and from the community. Letters to the editor and book reviews are welcome and will be published as space permits.

The principal aim in the preparation of a contribution should be relevance to diagnosis and treatment and to the education of patients and professionals. Preference will be given to authors from New Jersey and to out-of-state lecturers submitting a suitable manuscript based on a presentation made to an audience in New Jersey.

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Submit two manuscripts that must be typewritten and double spaced on 8½" by 11" paper. Statistical methods used in articles should be identified.

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1. Goldwyn RM: Subcutaneous mastectomy. *NJ MED* 74:1050-1052, 1977.

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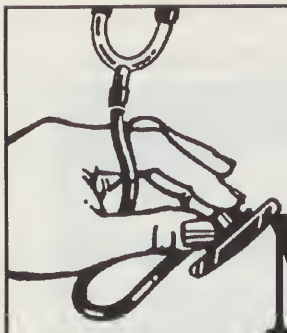
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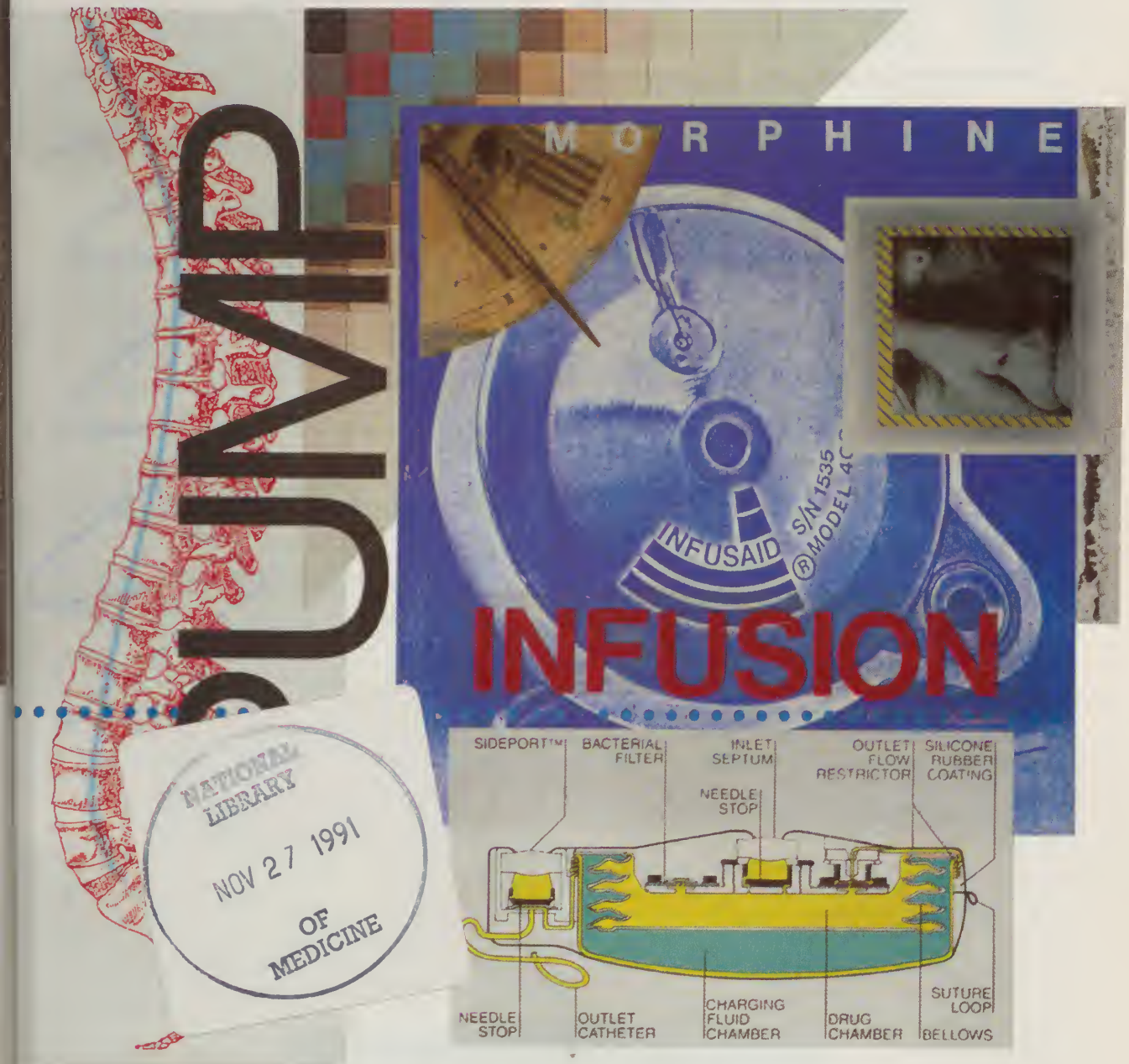
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November 1991

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Newswatch

BRACHFELD VERSUS MIIENJ...

Dr. Jonas Brachfeld, of Burlington County, has brought a class action suit against the Medical Inter-Insurance Exchange of New Jersey (MIIENJ), alleging breach of the subordinated loan agreements because MIIENJ paid dividends to 1977 policyholders. The subordinated loan money was used to form the surplus of the company. Dr. Brachfeld's suit asserts that MIIENJ should not have paid the dividends without redeeming the loans. MIIENJ and the Medical Society of New Jersey (MSNJ) believe the case is without merit.

The Court has ruled that the loans may only be redeemed upon approval of the insurance commissioner, which is what MIIENJ has asserted. The Court also ruled that a "class" is to be recognized to determine whether or not interest is payable and to what extent. The class certification process will be conducted through November 30, 1991. Subordinated loan holders receiving the Court notices will automatically be included in the "class" unless they "request exclusion."

MSNJ organized and formed MIIENJ, and a number of MSNJ officers and staff are involved in MIIENJ management and operation as it is the Society's endorsed professional liability carrier. The MSNJ Board does not believe the litigation has merit nor that it is in the best interest of MIIENJ and its current and future insureds. On October 20, 1991, the MSNJ Board of Trustees authorized an explanatory mailing to subordinated loan holders regarding the "class" certification issue.

MEDICARE RBRVS CONTINUES...

While Congress has issued a direct request to the Health Care Financing Administration (HCFA) to restore the proposed 16 percent reduction in the fee schedule conversion factor for 1992, the issue has not been resolved. HCFA has yet to fully respond to Congress and corrective legislation to override their lethargy has been introduced. The American Medical Association and MSNJ continue to work with Congress to overcome the arbitrary and capricious actions of HCFA and the Bush administration.

NOVEMBER ELECTIONS CRITICAL TO MEDICINE...

The outcome of the November state elections is not known at the time of this writing. The New Jersey Legislature, currently controlled by the Democrats, could end up with either or both Houses being led by Republicans in January. While the members of the Legislature generally do not form positions on health issues on a partisan basis, the governor's office has followed such a strategy.

So far, the Florio administration has pursued anti-medical themes in both no-fault and health care reform and continues to call for mandatory assignment in Medicare.

Physicians have been very active in this election process and have been bipartisan in their efforts. Hopefully, a reconstituted Legislature will deflect the misguided recommendations of the administration and will work toward corrections of the fatally flawed no-fault and health care reform measures.

November 1991

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The Cover

Trial periods of intraspinal opiate therapy provide information on patient response and side effects. Story begins on p. 797. Design: William & Philips.



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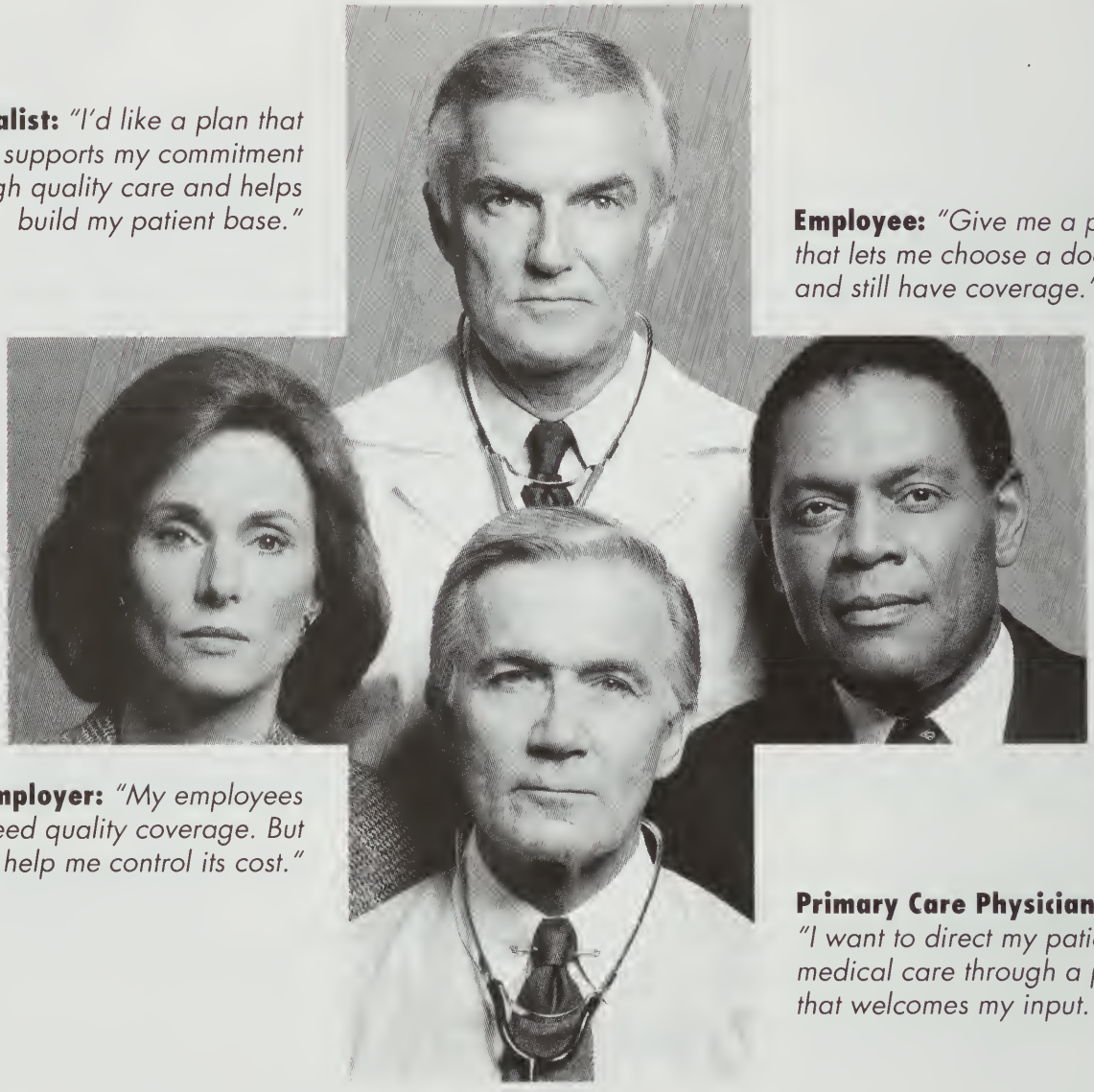
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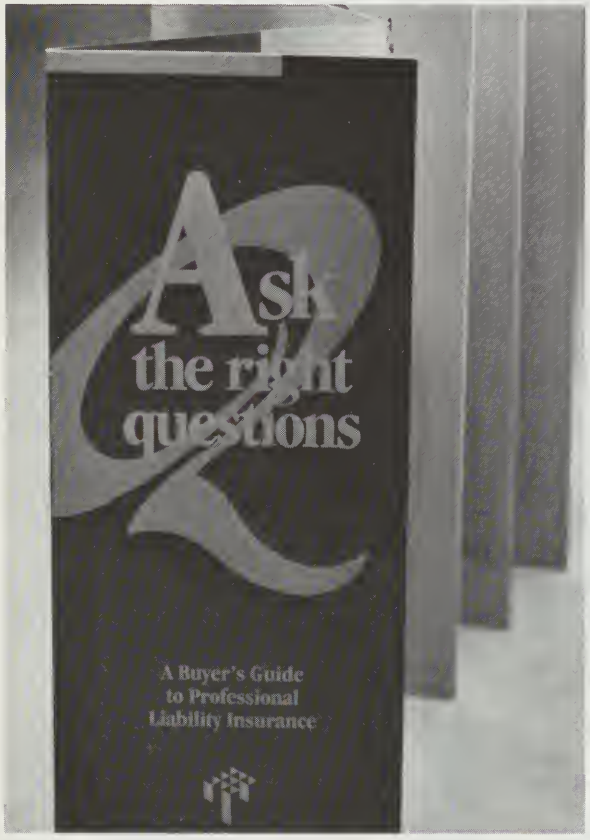
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MSNJ NEWSLETTER

SPECIAL SESSION OF THE MSNJ HOUSE OF DELEGATES

At the request of the Board of Trustees, a special session of the House of Delegates was convened on Sunday, September 15, 1991, at the executive offices of the Medical Society of New Jersey. One hundred eighty-nine delegates, representing 21 county societies, met for the sole purpose of reconsidering the Society's position on physician assistants.

The session was called to order at 9:30 AM, by President Joseph A. Riggs, MD. Fellow John S. Madara, MD, delivered the invocation.

The chairman of the Committee on Credentials, Carl Restivo, Jr, MD, reported that the necessary number of credentialled delegates was seated, and Secretary Bernard Robins, MD, advised that a quorum was present.

The president announced the following appointments for this meeting: Chief Teller, Robert I. Salasin, MD; Chief Sergeant-at-Arms, Frank L. Redo, MD; and Sergeants-at-Arms, S. Manzoor Abidi, MD, and Bessie M. Sullivan, MD.

Following comments by the president, and the executive director/general counsel, Vincent A. Maressa, the special session was turned over to the Speaker Karl T. Franzoni, MD, and Vice-Speaker Edward A. Schauer, MD.

After lengthy debate, the House of Delegates voted to sustain the Society's current position, which opposes the licensing or utilization of physician assistants. The meeting was adjourned at 11:00 AM.

IMPROVED ELIGIBILITY PROVISIONS

The Division of Medical Assistance and Health Services has submitted a proposed amendment to the New Jersey Care ... Special Medicaid Programs (*N.J.A.C.* 10:72) to the Office of Administrative Law. The amendment will appear in a future issue of *New Jersey Register.* The amendment provides an extended period for completing applications for Medicaid coverage for pregnant women who have been determined to be presumptively eligible for Medicaid benefits and simplified processing for those applications.

PAAD PROVISIONS

The Division of Medical Assistance and Health Services has submitted a proposed amendment to the Pharmaceutical Assistance for the Aged and Disabled (PAAD) Eligibility Manual (*N.J.A.C.* 10:69A) to the Office of Administrative Law. The amendment will appear in a future issue of *New Jersey Register.* The amendment provides increases in income limits for single individuals from $13,650 to $15,700; the income limit for married couples has been increased from $16,750 to $19,250. The PAAD Program enables eligible persons to receive prescribed legend drugs, insulin, insulin syringes, and diabetic testing materials.

All beneficiaries eligible for PAAD shall be granted eligibility retroactive to January 1, 1991, if their application was submitted to the Division by August 31, 1991. A public notice was distributed to New Jersey newspapers. PAAD beneficiaries who applied after September 1, 1991, had their applications processed and, if

eligible, were entitled to PAAD coverage prospectively, but not retroactively.

The proposed higher eligibility levels will provide assistance to approximately 36,000 additional beneficiaries who previously were ineligible for the program.

RBRVS

All 14 New Jersey representatives to the United States Congress signed a letter opposing the Health Care Financing Administration's proposed method of implementing Resource-Based Relative Value Scales (RBRVS). Citing information received from the Medical Society of New Jersey, the representatives stated that the proposal "represents a clear violation of congressional intent." In addition, Senator Bill Bradley joined in a Senate Finance Committee letter stating that Congress, when enacting the RBRVS requirement, "clearly anticipated that the fee schedule would neither increase nor decrease Medicare spending for physicians' services." Apparently what is clear to Congress is not always clear to administration officials. Both letters were sent to Health and Human Services Secretary Louis W. Sullivan, MD.

KNOWLEDGE OF HIV

The American Medical Association will conduct a national survey to determine primary care physicians' preparedness for treating patients with human immunodeficiency virus. The United States Centers for Disease Control is funding the mail and telephone survey of 12,000 physicians. The AMA is conducting the study with assistance from the National Medical Association, American Academy of Family Physicians, American Academy of Pediatrics, American College of Obstetricians and Gynecologists, American Society of Internal Medicine, and Society for Adolescent Medicine. The results will be available in mid-1992.

BIBLIOPHILIA AND MEDICAL HISTORY

The theme of the Annual Meeting of the Medical History Society of New Jersey (MHSNJ) is bibliophilia and medical history. Persons interested in presenting papers at the Annual Meeting should send a 200-word abstract to Barbara S. Irwin, MHSNJ Annual Meeting Program Chair, UMDNJ-George F. Smith Library, 30 12th Avenue, Newark, NJ 07103-2754. The program will include three papers, two talks on experiences of book collectors and book sellers, and displays and poster sessions by collectors and booksellers.

The Annual Meeting of MHSNJ will be held on Wednesday, May 13, 1992, at the headquarters of the Medical Society of New Jersey in Lawrenceville. For additional information, call the Academy of Medicine of New Jersey at 609/896-1717.

CDS RENEWAL APPLICATIONS

The Drug Registration section within the New Jersey State Department of Health (NJDOH) would like to make MSNJ members aware of the delay in mailing out renewal applications to those registrants whose certificates of registration expired on September 30, 1991. However, NJDOH emphasized the importance of retaining a copy (green) of the renewal application upon receipt and completion by the applicant until a certificate of registration is obtained. The delay by NJDOH should not affect the continuance of the professional practice of those practitioners to whom this notice applies. NJDOH expressed apologies for the inconveniences the delay might cause. □

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PROFESSIONAL LIABILITY

MALPRACTICE VERDICTS

May a malpractice jury award damages for loss of enjoyment of life to a comatose patient? Such payments, termed "hedonic damages," were the subject of a New Jersey appeals court decision that was highlighted in the nationally circulated "Personal Injury Newsletter."

The case, 247 N.J. Super. 435, 589 A.2d 653 (1991), involved a claim against a hospital and nurse for an injury that occurred in a postanesthesia care unit, or recovery room, in the alleged absence of proper monitoring of the patient. While the patient was in the unit, the patient's breathing stopped and then was restored. The patient lapsed into a coma that lasted for a year until his death.

Courts in diverse jurisdictions have taken alternative views of hedonic damages:

1. Most courts view hedonic damages as a component of pain and suffering, the major "noneconomic" form of damages.

2. Some courts deny any recovery for such loss of enjoyment of life.

3. Finally, some courts regard hedonic damages as distinct from pain and suffering.

In New York State, hedonic damages are recognized as part of pain and suffering, provided that the plaintiff is aware of the loss—that a comatose plaintiff, presumably, is not. *McDougald v. Garber,* 73 N.Y.2d 246, 538 N.Y.S.2d 937, 536 N.E.2d 372 (1989). By contrast, West Virginia regards such damages as compensable even if the victim is not cognizant of the loss. *Flannery v. United States,* 297 S.E.2d 433 (W.Va., 1982).

The New Jersey appellate court came down on the side of West Virginia. The court argued that loss of enjoyment is qualitatively different from pain and suffering. Indeed, in New Jersey an interruption of mental and physical function constitutes a disability or impairment. The court further ruled that such a loss exists whether or not the individual is aware of it.

Better news for defendants emerged from a Passaic County court, where a jury in June ruled in favor of a gastroenterologist accused of negligently perforating a colon during a colonoscopy and then failing to diagnose and treat the injury in a timely manner. In part, the defendant's success was attributed to three strategies:

1. To rebut the plaintiff's expert testimony that the perforation would not have occurred in the absence of negligence, the defense presented statistical evidence that perforation is a complication that occurs in approximately 1 percent of cases. Although the complication is rare, said the defense, it is not necessarily caused by negligence.

2. To support the defendant's contention that a surgeon consulted about the perforation opposed immediate surgical repair, the defense showed that the surgeon's own records indicated that the surgeon favored a conservative approach. The surgeon claimed that he had urged immediate surgery, and subsequently he was dismissed as a codefendant.

3. The defense used the plaintiff's Social Security records to show that the plaintiff had difficulty performing everyday tasks even before the surgery, thus undermining the plaintiff's claim that the alleged malpractice prevented him from performing such tasks.

According to the plaintiff's

claims, a colostomy eventually had to be performed and later was reversed surgically. However, an incisional hernia was sustained during the reversal, the small intestine was nicked during surgery to repair the incisional hernia, and additional surgery was needed to repair the intestinal damage. According to the defense, the plaintiff had a black lung condition and was very fragile, so that immediate surgery to repair the perforation was considered too risky.

In Florida, a chiropractor lost an appellate court decision regarding whether a physician could present expert evidence against the chiropractor. A board-certified neurosurgeon had submitted an affidavit declaring that the chiropactor had fallen short of the standard of chiropractic care by failing to refer the plaintiff patient for a timely neurologic consult. The decision reversed a lower court's dismissal of the affidavit and of the malpractice case against the chiropractor.

The case of Libby Zion, whose 1984 death at age 18 sparked reform of emergency department house staff regulations in New York State, finally may be closed. Her family physician was cleared of negligence. Earlier, an emergency department intern and resident at New York Hospital-Cornell Medical Center, New York, were found grossly negligent. The new regulations limit the number of consecutive hours that interns and residents may be on duty.

MALPRACTICE POLICY DEVELOPMENTS

Only 43 percent of malpractice litigation costs go to patients and families, according to a Rand Corporation study. The rest are administrative costs and legal fees. Cost effectiveness obviously is not a hallmark of this system.

Vice-President Dan Quayle "walked away an easy winner" from his tort reform speech at the annual meeting of the American Bar Association, according to a *Washington Post* editorial. The vice-president claimed that the United States spends about $300 billion annually on litigation and related insurance costs. Mr. Quayle specifically supported limits on punitive damages, which he said should be awarded by a judge, not a jury, in a separate proceeding. Mr. Quayle's concerns about costs relate to his role as chairman of the President's Council on Competitiveness.

Tort reform also was backed by the American Law Institute in a study, *Enterprise Liability for Personal Injury.* As noted in our August commentary, the Institute study contended that hospitals, not physicians, should bear the brunt of liability. The report argued that the tort system has become a form of mandatory disability insurance, rather than the system of corrective justice between individuals that originally was conceived. It also supported a scale of damages for pain and suffering, and a list of mitigating and aggravating factors that would be used to make awards more predictable and, hence, encourage more out-of-court settlements.

Even more evidence in favor of tort reform emerged from a recent Georgetown University study of an American Medical Association proposal. The proposal is for state medical practice review boards to adjudicate malpractice claims, strengthen physician discipline and credentialing, and serve as clearinghouses of information about physician performance. The researchers' conclusion is that the proposal could improve the quality of health care. The researchers further concluded: "A fault-based administrative agency could be one of the best public policy bargains to emerge in the health field."

Not all criticism of the tort system may be on the mark, however. Writing in the second issue of a new health policy journal, economist Frank Sloan

argued that, contrary to expectations, limits on the amount of awards would not slow the litigation pipeline. Sloan examined 187 Florida suits from 1989 to 1990 and found that families generally sue to gain retribution and to "find out what happened." His findings also reinforce the conventional malpractice wisdom that poor physician communication with patients leads to suits—even, Sloan says, when the physician and patient had an established relationship. (Sloan FA: Winners and losers: How medical malpractice disputes are resolved. *J Am Health Policy* 1:20-25, 1991.)

A special report of "Medical Liability Monitor," dated August 16, 1991, focused on trends in malpractice insurance premiums among various specialties. In general, the rate review found that a majority of 35 surveyed companies have continued to reduce their premiums in 1991, although some companies have increased premiums, especially for internists. Obstetrician-gynecologists (OBGs) have enjoyed the greatest rate reductions. Median premiums in June 1991 were $5,478 for internists, $21,490 for general surgeons, and, despite reductions, $202,338 for OBGs. The report covered $1M/$3M mature claims-made policies.

AIDS ISSUES

The Medical Society of New Jersey's House of Delegates received authoritative confirmation of the wisdom of its 1991 Resolution #4 from the Centers for Disease Control (CDC) on September 19, almost five months after the resolution urging "universal" HIV testing of patients and health care personnel was passed. The new CDC draft guidelines recommended that hospitals "routinely offer and encourage" HIV patient testing.

Adoption of draft Occupational Safety and Health Administration (OSHA) regulations requiring universal precautions would be accelerated under legislation that passed the U.S. Senate on September 18. The vote was 99-1.

CDC has been trying to discover how Florida dentist David Acer transmitted HIV to patients. Dr. Acer remains the only practitioner known to have infected patients with HIV. According to CDC indications, the dental handpiece was the mode of transmission.

In a potential landmark suit to bar disclosure of a practitioner's HIV status, an Illinois dentist who worked in a federal prison in Chicago is seeking to prevent the federal Bureau of Prisons from notifying inmates and former inmates of the dentist's seropositivity. The suit was filed on August 9, 1991.

LIVING WILLS

December 1, 1991, will mark the implementation of federal requirements that hospitals provide written information to patients about patients' right to issue advance directives under state law. The new requirements are a Medicare mandate. New Jersey's comprehensive advance directives legislation takes effect in January 1992. Lawyers' reservations about the federal requirements were aired in the September issue of the "Hospital Law Newsletter."

LIABILITY TIPS

Ectopic pregnancy incidence has tripled during the past 20 years. Delayed diagnosis of this condition is emerging as a major factor in malpractice litigation.

Classic signs of ectopic pregnancy are abdominal pain, lack of menses, and vaginal bleeding. Diagnostic pitfalls include failing to take an adequate history, ignoring signs of blood loss, misinterpreting diagnostic tests,

and failing to heed patient complaints. Predisposing factors include a prior ectopic pregnancy, a history of pelvic inflammatory disease, intrauterine device (IUD) use, a tubal ligation, and a history of infertility.

Physicians sometimes ignore a vague intermittent pain described by patients. Dizziness and blood pressure changes on standing also can signify an ectopic pregnancy. (Abbot J, et al.: *Am J Emerg Med* 8:515-522, 1990.)

NATIONAL PRACTITIONER DATA BANK

Physicians are well advised to disclose previous losses of hospital privileges when applying for privileges at a different hospital. Such information now is sent to hospitals through the National Practitioner Data Bank. Last year, a physician was found guilty in New York State of unprofessional conduct for failing to disclose such information. *Kleinder v. Sobol,* 557 N.Y.S.2d 588, App. Div., 1990. In New Jersey, too, unprofessional conduct can lead to suspension or revocation of a physician's license.

BUSH ADMINISTRATION GRADES

The Journal of American Health Policy was inaugurated this summer and immediately issued a "health report card" on eight Bush administration health policymakers. Office of Management and Budget Director Richard G. Darman received an "A" for his widely publicized efforts to curtail federal health expenditures. A grade of "A-minus" went to Health Care Financing Administration Administrator Gail R. Wilensky, PhD (point person for the RBRVS proposal vehemently opposed by organized medicine) and CDC Director William L. Roper, MD, MPH, who spearheads action on HIV testing issues.

Less generously evaluated was Dr. Roper's predecessor and supervisor, Assistant Secretary for Health James O. Mason, MD, who was given a "B-minus" and the comment that making up his mind is "reportedly a difficult task." Secretary of Health and Human Services Louis W. Sullivan, MD, garnered only a "C-plus."

Surgeon General Antonia C. Novello, MD, "no Everett C. Koop," received a "D" for being "virtually invisible, popping up occasionally to criticize the marketing of a high-octane wine cooler." Incompletes went to David A. Kessler, MD, commissioner of the Food and Drug Administration, and Bernadine P. Healy, MD, director of the National Institutes of Health.

PROFESSIONAL LIABILITY

This monthly commentary is prepared by the Department of Professional Liability Control of the Medical Society of New Jersey (MSNJ), James E. George, MD, JD, director. Participating in the preparation of the commentary is Neil E. Weisfeld, JD, MSHyg, director, education, research & regulatory affairs, MSNJ. □

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The following is a brief summary only. Before prescribing, see complete prescribing information in Zantac® product labeling

INDICATIONS AND USAGE: Zantac® is indicated in:

1. Short-term treatment of **active duodenal ulcer.** Most patients heal within four weeks.
2. **Maintenance therapy** for duodenal ulcer patients at reduced dosage after healing of acute ulcers.
3. The treatment of **pathological hypersecretory conditions** (eg, Zollinger-Ellison syndrome and systemic mastocytosis).
4. Short-term treatment of **active, benign gastric ulcer.** Most patients heal within six weeks and the usefulness of further treatment has not been demonstrated.
5. Treatment of **gastroesophageal reflux disease (GERD).** Symptomatic relief commonly occurs within one or two weeks after starting therapy and is maintained throughout a six-week course of therapy.

In active duodenal ulcer; active, benign gastric ulcer; hypersecretory states; and GERD, concomitant antacids should be given as needed for relief of pain.

CONTRAINDICATIONS: Zantac® is contraindicated for patients known to have hypersensitivity to the drug.

PRECAUTIONS: General: 1. Symptomatic response to Zantac® therapy does not preclude the presence of gastric malignancy. 2. Since Zantac is excreted primarily by the kidney, dosage should be adjusted in patients with impaired renal function (see DOSAGE AND ADMINISTRATION). Caution should be observed in patients with hepatic dysfunction since Zantac is metabolized in the liver.

Laboratory Tests: False-positive tests for urine protein with Multistix® may occur during Zantac therapy, and therefore testing with sulfosalicylic acid is recommended.

Drug Interactions: Although recommended doses of Zantac do not inhibit the action of cytochrome P-450 enzymes in the liver, there have been isolated reports of drug interactions that suggest that Zantac may affect the bioavailability of certain drugs by some mechanism as yet unidentified (eg, a pH-dependent effect on absorption or a change in volume of distribution).

Pregnancy: ***Teratogenic Effects: Pregnancy Category B:*** Reproduction studies have been performed in rats and rabbits at doses up to 160 times the human dose and have revealed no evidence of impaired fertility or harm to the fetus due to Zantac. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

Nursing Mothers: Zantac is secreted in human milk. Caution should be exercised when Zantac is administered to a nursing mother.

Pediatric Use: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS: Headache, sometimes severe, seems to be related to Zantac® administration. Constipation, diarrhea, nausea/vomiting, abdominal discomfort/pain, and, rarely, pancreatitis have been reported. There have been rare reports of malaise, dizziness, somnolence, insomnia, vertigo, tachycardia, bradycardia, atrioventricular block, premature ventricular beats, and arthralgias. Rare cases of reversible mental confusion, agitation, depression, and hallucinations have been reported, predominantly in severely ill elderly patients. Rare cases of reversible blurred vision suggestive of a change in accommodation have been reported.

In normal volunteers, SGPT values were increased to at least twice the pretreatment levels in 6 of 12 subjects receiving 100 mg qid intravenously for seven days, and in 4 of 24 subjects receiving 50 mg qid intravenously for five days. There have been occasional reports of hepatitis, hepatocellular or hepatocanalicular or mixed, with or without jaundice. In such circumstances, ranitidine should be immediately discontinued. These events are usually reversible, but in exceedingly rare circumstances death has occurred.

Blood count changes (leukopenia, granulocytopenia, thrombocytopenia) have occurred in a few patients. These were usually reversible. Rare cases of agranulocytosis, pancytopenia, sometimes with marrow hypoplasia, and aplastic anemia have been reported.

Although controlled studies have shown no antiandrogenic activity, occasional cases of gynecomastia, impotence, and loss of libido have been reported in male patients receiving Zantac, but the incidence did not differ from that in the general population.

Incidents of rash, including rare cases suggestive of mild erythema multiforme, and, rarely, alopecia, have been reported, as well as rare cases of hypersensitivity reactions (eg, bronchospasm, fever, rash, eosinophilia), anaphylaxis, angioneurotic edema, and small increases in serum creatinine.

OVERDOSAGE: Information concerning possible overdosage and its treatment appears in the full prescribing information.

DOSAGE AND ADMINISTRATION: (See complete prescribing information in Zantac® product labeling.)

Dosage Adjustment for Patients with Impaired Renal Function: On the basis of experience with a group of subjects with severely impaired renal function treated with Zantac, the recommended dosage in patients with a creatinine clearance less than 50 ml/min is 150 mg or 10 ml (2 teaspoonfuls equivalent to 150 mg of ranitidine) every 24 hours. Should the patient's condition require, the frequency of dosing may be increased to every 12 hours or even further with caution. Hemodialysis reduces the level of circulating ranitidine. Ideally, the dosage schedule should be adjusted so that the timing of a scheduled dose coincides with the end of hemodialysis.

HOW SUPPLIED: Zantac® 300 Tablets (ranitidine hydrochloride equivalent to 300 mg of ranitidine) are yellow, capsule-shaped tablets embossed with "ZANTAC 300" on one side and "Glaxo" on the other. They are available in bottles of 30 (NDC 0173-0393-40) tablets and unit dose packs of 100 (NDC 0173-0393-47) tablets.

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Store between 15° and 30° C (59° and 86° F) in a dry place. Protect from light. Replace cap securely after each opening.

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September 1990

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BOOK REVIEWS

THE ART OF GENERAL PRACTICE

David Morrell. New York, NY, Oxford University Press, 1991. The first edition of *The Art of General Practice* appeared in 1965 after the author's initial five years in general practice. Dr. Morrell wrote, "It was designed to help new doctors entering general practice. It became increasingly popular among medical students and has been used as a course book throughout the world." I agree fully; the book is for third- and fourth-year students, but not for practicing physicians. This text is a well-placed orientation to primary care, a good "first" book. Readers who already are clinicians, however, will think of giving the text as a gift rather than reading it themselves.

The Art of General Practice is a clear exposition of the general principles of managing patients. There are nine chapters: "Teaching and Learning in General Practice"; "Primary Medical Care"; "The Characteristics of General Practice"; "Solving Problems in General Practice"; "History Taking in General Practice"; "Examination of the Patient in General Practice"; "Prognosis"; "Prevention, Health Education, and the Primary Care Team"; and "Treatment." Brief case studies are mentioned throughout the text. There is a five-page index.

Dr. Morrell, professor of general practice, has touched all the important bases. Examine it for younger colleagues. ☐ Morris Soled, MD

BORN TOO SOON

Elizabeth Mehren. New York, NY, Doubleday, 1991. This is an autobiographical account of the fertility workup, pregnancy, labor, and delivery of an "elderly primipara" and of the tragic neonatal course of her tiny premature baby. This story does not become deeply immersed in the usual brand of "doctor-bashing" to which we have become accustomed, if not inured. It does illustrate how improved medical technology and better statistics have served to increase the public expectations of even better results. It is not possible to come away from this sad story without feeling empathy for the large numbers of intelligent, talented women who postpone pregnancy while pursuing their careers. This book is well written and the author ultimately achieves a successful pregnancy, yet it is difficult to decide for whom this book should be recommended. ☐ Jerome Abrams, MD

FUNCTIONAL ENDOSCOPIC SINUS SURGERY

Heinz Stammberger, MD. Philadelphia, PA, B.C. Decker, 1991. It is a pleasure and honor to review this book that will become the "bible" of endoscopic sinus surgery. The surgical procedure, a wonderful advancement in the treatment of sinus disease, has become popular in the past few years in the United States. This procedure literally has turned around the surgical treatment of sinus disease. In the past, many of the surgeries were radical in nature, and now the same diseases can be treated with same-day procedures with significantly less morbidity.

Up until now, there have been few well-written books; they have not been all encompassing. This book encompasses all aspects, from the history of nasal endoscopy to the principles of secretion transportation, performed by Professor Messerklinger in Austria. This formed the basis for the future of this surgery. Dr. Stammberger shows the exact anatomy necessary to understand the disease and the surgery. The line drawings, along with the pictures, are excellent. The diagnosis actually is twofold: endoscopy of the nose, which is done preoperatively, and radiologic diagnosis.

As one reads each chapter, it is easy to become excited with the completeness and clarity with which the concepts are presented. The book goes on to give the indications for endoscopic surgery and then, in great detail, the surgical technique. Preoperative and postoperative care are discussed, as well as special problems.

This book is absolutely essential for otolaryngologists involved with the treatment of sinus disease. Furthermore, physicians with an interest in sinus disease can study the chapters that would be of educational value.

It is somewhat rare that a book completely exposes the topic in question with such completeness and clarity; this book deserves only the highest accolades. □
Harold Arlen, MD

MAGNETIC RESONANCE IMAGING OF THE BRAIN AND SPINE

Scott W. Atlas (ed). New York, NY, Raven Press, 1991. The scope of knowledge necessary to interpret magnetic resonance imaging (MRI) scans combines a technical, pathological, and clinical understanding of the field. Dr. Atlas has edited an outstanding reference text embracing these broad parameters. He has assembled contributions from an impressive array of authorities to achieve a work that includes everything from instrumentation and safety considerations to neurodegenerative diseases and congenital spine anomalies.

The opening chapters adopt a nonmathematical approach to the subject of MR physics, which makes the material easily accessible. The greater part of the book considers the brain itself.

While the entire volume is superbly composed, special praise is warranted for the chapters on brain development by Dr. A. James Barovich, and on vascular malformations and aneurysms by Dr. Atlas. These analyses are noteworthy for their comprehensiveness as well as for the state-of-the-art images. Overall, the sections examining the spine match the other chapters in quality. Here, I single out the discussion of congenital anomalies by Dr. Thomas Nadich for his meticulous attention to detail and organization. The chapters concerning osteomyelitis could have been expanded to be as all-encompassing as the rest of the book. Coverage of the cutting-edge technologies of MR angiography and spectroscopy round out this excellent text. The effort to produce this work was obviously enormous, and the resulting wealth of knowledge makes this textbook a highly recommended selection for all physicians. □
Neil B. Horner, MD

BOOK REVIEWS

Book reviews are welcomed by the editor-in-chief. Reviews will be peer reviewed and are subject to editing. Publication will be on a space available basis. Address letters and reviews to Howard D. Slobodien, MD, Editor-in-Chief, *NEW JERSEY MEDICINE*, Two Princess Road, Lawrenceville, NJ 08648.

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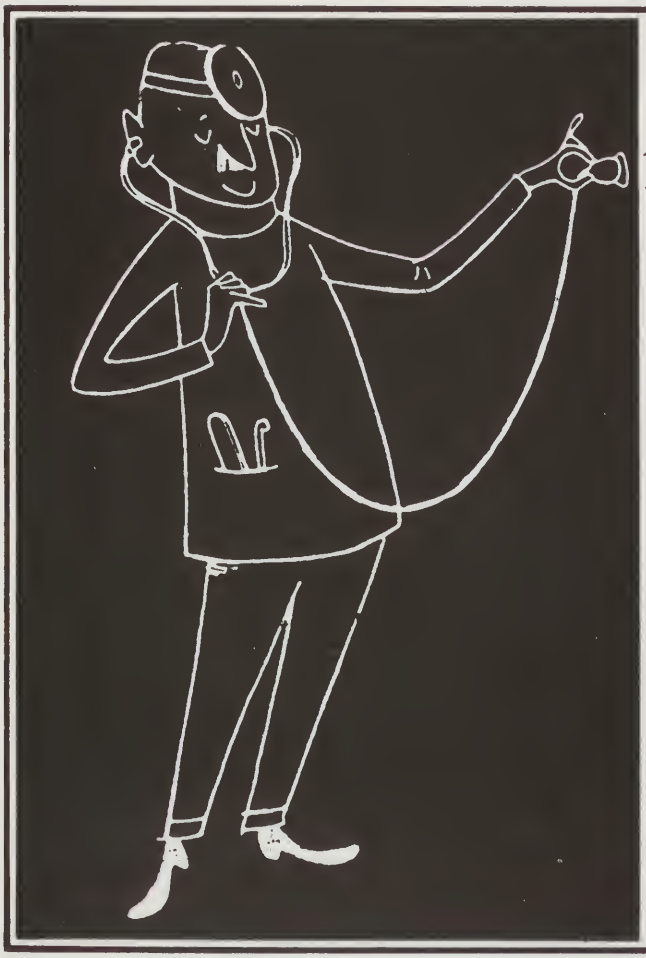
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LETTERS AND VIEWPOINTS

DILTIAZEM AND THE ELDERLY

One of the therapeutic indications of diltiazem is for the treatment of hypertension. However, as with other pharmacological agents, its use should be evaluated carefully in the elderly, particularly in patients with underlying cardiac conduction system disease.

Diltiazem has been shown to prolong the A-H interval and PR interval in normal individuals and in patients with first degree atrioventricular (AV) block.[1,2] Its use in patients with second and third degree AV block is contraindicated, unless a functioning ventricular pacemaker is present.[3] Diltiazem use in patients with a bundle branch block requires careful initiation and titration of the dose.[4] It has been shown to cause complete heart block, alone or with other agents.[8,9] There are only a few reports on the effect of diltiazem on sinoatrial (SA) node in humans.[5,6,10,11] Animal in vitro studies have documented the inhibitory effect of diltiazem on the SA and AV nodes via the slow calcium channels.[7]

Case report. We examined an 83-year-old woman with a more than ten-year history of hypertension, right bundle branch block (RBBB), and left anterior hemiblock (LAHB), and a blood pressure (BP) of 200/100 mm Hg. Diuretics were discontinued and diltiazem, 90 mg twice a day, was started. Within 24 hours, she was noted to be confused; by the next day, she was found on the floor and poorly responsive. The paramedic team recorded a BP of 100/46 mm Hg, a pulse of 30/min, and a respiratory rate of 4 breaths/min. She was immediately intubated.

On arrival in the emergency room, the patient was lethargic and intubated, with a BP of 100/40 mm Hg and pulse of 30/min. She was found in congestive heart failure as evidenced by a ventricular gallop, bibasilar pulmonary rales, and trace leg edema. A 12-lead electrocardiogram (ECG) showed no atrial activity, a QRS duration of 130 ms, a ventricular rate of 28/min, and a pattern of RBBB with LAHB. Her mental status, BP, and congestive heart failure improved after insertion of a temporary VVI pacemaker and administration of intravenous furosemide. Within several hours, the patient was extubated, and within 18 hours the rhythm reverted to sinus with RBBB and LAHB. Plazma diltiazem levels were 120 and 50 ng/ml, respectively, 8 and 24 hours after admission; therapeutic levels were 50 to 200 ng/ml. The diltiazem level on admission was 200 ng/ml.

Atrial asystole and profound junctional bradycardia were felt to be due to diltiazem, since sinus rhythm reappeared as the diltiazem level fell. Diltiazem should be used cautiously in the elderly, especially in those with underlying conduction disease due to its effect on SA and AV nodes. Diltiazem-induced sinus node dysfunction can be treated by temporary pacing to avoid further complications such as congestive heart failure, asystole, and malignant tachyarrhythmias. □

Koroush Khalighi, MD; Israel J. Mantecon, MD; and Ernest E. Federici, MD, Seton Hall University.

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EDITOR'S DESK



RUMINATIONS ON GOVERNMENT

Government is an employer of the first magnitude in both state and federal versions. It is all pervasive, entering all aspects of American life. It does much more than provide and assure protection, security, and educational benefits. It does much more than take from the rich and give to the poor. (It sometimes confuses things and reverses the process.) Its intrusion into many aspects of life is so well-entrenched that it seems almost un-American to be an individual, to provide for one's self and one's family, to suggest pay-as-you-go, or to decry the exponential growth of government, and its death grip on too much of the delivery of health care in our nation.

We have belatedly recognized the potentially great historical stature of President Lyndon Johnson and his Great Society, scuttled by the disasters of the Vietnam War. His forceful introduction of Medicare and Medicaid changed, probably forever, the face of American medicine. Some of us still can recall the American Medical Association (AMA) thrust for acceptance of Eldercare as a substitute for Medicare and the meteoric rise of Ed Annis of Florida, who became the eloquent spokesman for Eldercare and, subsequently, despite an unsuccessful effort, the president of the AMA. More of us should recall the intensive campaign by President Johnson to enroll the Medicare recipient into Part B; his success helped to soften some of the negative effects of the program by adding substantial numbers of paying patients.

But potential costs of the federal programs were severely underestimated, partly because the planners ignored a basic tenet—that people with insurance use medical care much more than those without coverage. Potential cost estimates continue to be unrealistic. Let us also remember the history of the war on poverty. President Johnson estimated that 30 million people needed help. (The official figure was closer to 27 million.) Seven years ago there still were 29 million "poor" people. At that time, statistical analysis suggested that, had the money in the program been given directly to the needy, each family of four would have had an annual income of $44,000. Today we have an estimated 33 million individuals in this economic category. So much for governmental efficiency. (Need we review the impact of the Great Society's drive to elevate educational standards?)

In the early 1970s, President Nixon, model of rectitude, imposed a fee and salary freeze on physicians and hospital workers, with allowable increases of 2.5 percent for the former and 5 percent for the latter. Those who changed positions, by title and job description, were excluded from the freeze. That is how hospital administrators became directors, then vice-presidents, then executive vice-presidents, and then presidents. Those familiar with military tables of organization know that higher ranks require more layers of personnel beneath them; the augmented tiers in our hospitals fit the pattern. (To be fair, more people have been needed because of the huge increase in the number of governmental regulations and the associated paperwork.) Physicians had fewer options and many were "stuck" with antiquated fees that had not been raised in years. As a result, fueled by this pernicious program, many of these physicians vowed "never again" and the business side of medicine assumed proportions that, today, many of us feel have escalated beyond the bounds of professionalism.

New Jerseyans are familiar with some of the state problems of hospital reimbursement. Most of these problems are produced or complicated by governmental action or inaction. Reimbursement for the uninsured and indigent was a problem long before a state fund was created. Our state and local governments never paid their shares. About half the cost was repaid from taxes; the rest depended on voluntary contributions. The cost shifting that astonishes many of the newly informed is not of recent vintage. Years ago, Blue Cross and Blue Shield received hefty discounts from hospital charges and so did compensation cases. Today's shifts, tied to inadequate payments to hospitals, therefore, are merely following a longstanding trend. It also is not surprising that the federal government, whose cost shifting in the Medicare-Medicaid programs helps to create the pool of underinsureds, should continue to coerce physicians to accept Medicare assignment in all cases, despite the cost shifting involved from the needy Medicare patient to the affluent one who can well afford a semi-decent fee, and from all Medicare patients to the younger wage earners who have subsidized the program from its onset. It does not matter that more than four out of five doctors accept assignment, some always, even more whenever requested. It does not matter that the fees are a disgrace, are based on outdated ones from 1983, and are being further ratcheted down, despite the continually escalating costs of practice and (just) living.

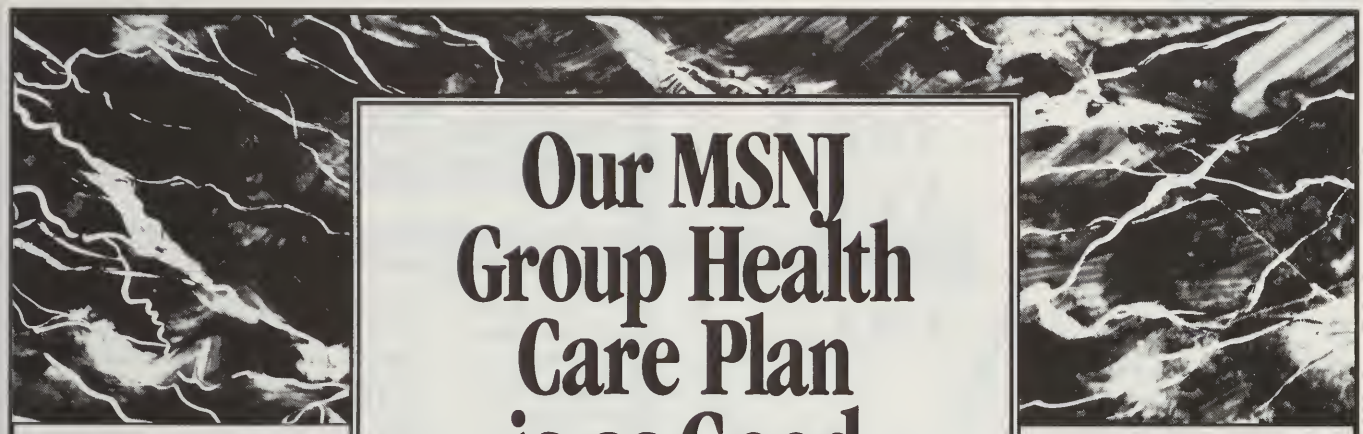
We find it obscene that our economic health is being undermined by so-called public servants who sneak massive pay increases for themselves at public (taxpayer) expense, during a most distressing recession. Is it time for us to reconsider, as has George Will, limiting terms for our rubber-check writing representatives?

At the end of the longest period of prosperity in memory, over 30 million Americans were not properly insured against health and medical expenses. As we noted earlier, governmental edicts have added an Everest of costs for hospitals. They also have placed an Alpine burden on practicing physicians. Economics experts estimate that a mere 25 percent of these costs of doing business could pay for the coverage of all the aforementioned underinsured. But you can bet that government prefers to, and will, place the onus on our shoulders. Government is good at making regulations, but totally deficient at budgeting. The failure of such programs as the war on poverty and the appalling ever-increasing federal debt should bear vivid testimony to the fiduciary and financial ineptitude of our national government. Our state government cannot, by law, dump its citizenry into the same monetory hole as its federal counterpart, but it also shows a lack of knowledge, concern, or guts in its handling of uncompensated care. Doctor Molly Joel Coye, our previous Commissioner of Health, estimated the value of uncompensated care provided by New Jersey physicians during her term as $500 million per annum. Do you think our state government cares? Or the federal government?

But I do run on. Enough for now. We shall return to this depressing and seemingly inexhaustible topic at a later date. □ Howard D. Slobodien, MD

Families are as unique as fingerprints, while the rubber stamp is the escutcheon of government.

Anna Quindlen, *The New York Times* (September 21, 1991)



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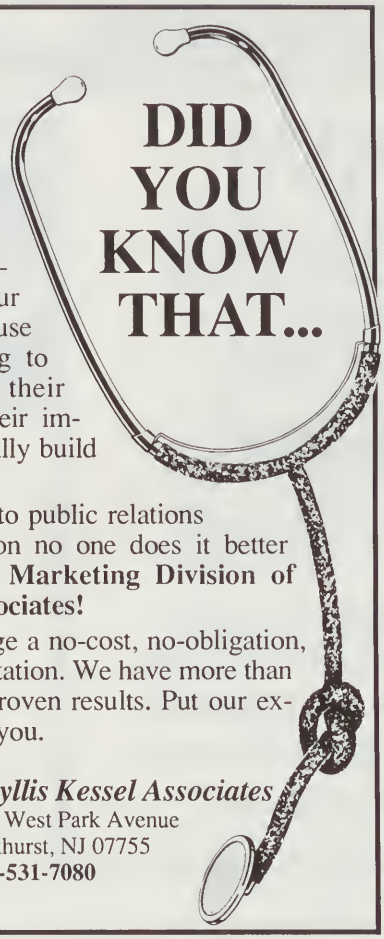
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PRESIDENT 'S PAGE



ADVANCE DIRECTIVES FOR HEALTH CARE

Despite the sense of novelty that surrounds the issue, advance directives are not new. As early as 1914, courts recognized that: "Every human being of adult years, of sound mind, has the right to determine what shall be done with his own body."

In later years, court rulings became even more explicit: "No right is held more sacred, no right is more clearly guarded by law, than the right of every person to control his destiny, free from all restraint and interference."

In October 1990, federal legislation—"The Patient Self-Determination Act"—was passed, to take effect for all Medicare and Medicaid patients in December 1991. Many hospitals now are conducting seminars to familiarize their administrative staffs, medical and nursing staffs, and admissions office personnel with their new responsibilities under both the federal law and S-1211, the New Jersey "Advance Directives for Health Care Act," which will take effect January 7, 1992.

These acts support the right of individuals to specify in writing the circumstances under which any life-sustaining treatments should—or should not—be undertaken in cases of injury or illness. The laws also support the durable power of attorney, so that individuals may select someone to serve as a health care representative, proxy, advocate, or surrogate, empowered to decide about life-sustaining treatments on the individual's behalf.

The two principal goals of these laws are very clear: to respect and promote patient autonomy, and to foster the well-being of the patient.

The public has become increasingly concerned about death protracted by invasive machines, incapacities, intolerable pain, and indignity. Beginning in 1973 with the case of Karen Ann Quinlan in New Jersey, publicity about legal issues of death and dying have activated the public.

Until recently, death has been thought of as the ultimate enemy, to be fought to the bitter end. Now, people are beginning to accept the inevitable. Physicians are beginning to accept the desires of their patients for a dignified, timely death.

Despite widespread acknowledgment of the need for individuals to prepare advance directives, few people have done so. Perhaps patients and physicians each wait for the other to raise this sensitive subject. And, most young persons believe that advance directives are only for the elderly and infirm. A recent AMA survey indicated that 56 percent of those surveyed have discussed their treatment preferences with family members and friends, but fewer than 15 percent have actually completed an advance directive. Another study conducted at nursing homes indicated that 90 percent of those patients have heard of advance directives but only 18 percent have signed one. The new federal and state laws should change all that.

The recommended forms for advance directives in New Jersey are contained in a booklet provided by the state Bioethics Commission, CN-061, Trenton, New Jersey, 08625, for $1.00 postage on an enclosed, self-addressed 9″ x 12″ envelope. People who find it difficult and confusing to complete the form for specific instructions, can instead complete a simpler form naming a proxy. MSNJ recommends these forms because they are complete, official, and tailored to the new state law.

In an effort coordinated by our Committee on Seniors, our county medical societies now are planning senior citizen forums throughout the state. At these forums, physicians and other experts will discuss advance directives.

As physicians, we must explain the medical aspects of advance directives to our patients and the public in clear and precise terms. These issues should be part of the clinical process—not just an administrative process. Clearly, the day of hospital admission is not the best time to initiate discussion about advance directives. Ideally, this should be done in the patient's home or physician's office when the patient is relaxed and well. Although many families do not discuss these matters routinely, there is no substitute for family discussion, because the families usually make decisions for a person who becomes incapacitated.

The New Jersey Hospital Association has developed a manual for hospitals to frame procedures for carrying out the wishes of patients being admitted. However, many aspects of these important issues require physician involvement. Physicians can offer patients their knowledge and support. Physicians can decrease anxiety about dying and be a source of comfort. They can promote a sense of well-being about proper control of one's destiny. As physicians, we should be willing to do no less for our patients. God bless! ☐ Joseph A. Riggs, MD

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Epidural Trial in Implantation of Intrathecal Morphine Infusion Pumps

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A 15-patient study indicated that trial periods of intraspinal opiate therapy via a temporary cutaneous epidural catheter are not reliable for predicting initial pain-relieving dosages, but trial periods do provide information pertaining to patient response and side effects.

During the past decade, the use of intrathecal opiates, delivered continuously via implantable pumps, has represented a significant advance in pain control therapy. This modality has proved especially beneficial in treatment of the severe, unrelenting pain experienced by cancer patients. It has been estimated that 71 percent of all patients in the terminal stages of cancer report substantial pain.[1] While many of these patients obtain pain control by conventional analgesics, a significant number remain uncontrolled or at doses producing intolerable side effects, i.e. lethargy, anorexia, insomnia, dysphoria, confusion, and hallucinations.[2]

Continuously infused intrathecal opiates have offered an alternative therapy for patients with chronic intractable pain by greatly lowering narcotic dosages without effecting light touch, automatic outflow, or voluntary motor function. The side effects associated with high-dose systemic narcotics also are avoided. However, these spinal opiates are not without potential adverse reactions such as respiratory depression, urinary retention, pruritus, nausea, and vomiting.[3] Therefore, it is essential that patients receiving these opiates be monitored closely and that their lowest effective pain relieving dose be identified.

After careful assessment for implantation of a permanent intrathecal morphine pump, our patients undergo a prepump protocol similar to that described by Penn and Paoce.[4] This consists of a trial of intraspinal opiate therapy via a temporary percutaneous epidural catheter. The purpose of this prepump epidural catheter trial is to determine the patient's response to intraspinal opiates to provide information relative to systemic side effects and to predict an initial pain relieving intrathecal dosage for the permanent pump.

A review of Brazenor's work reveals that not all protocols utilize a preimplant trial period.[5] Although this period provides important reassurance to the patient as to the effectiveness of this pain-relieving modality, could the length of the hospitalization be shortened by eliminating the two to three days required for this trial of epidural morphine?

During a four-year period, 30 patients were evaluated for chronic intractable pain due to various malignancies. All patients underwent a prepump epidural catheter protocol and then had implanted permanent intrathecal continuous infusion pumps for the delivery of opiates. A retrospective review of these medical records indicated there was incomplete data on 15 of the 30 patients; therefore, the incomplete records were excluded from the review. We report the results of our remaining 15-patient review.

MATERIALS AND METHODS

Patients. Between 1985 and 1989, 30 patients with intractable, narcotic-dependent pain were evaluated and determined to be candidates for implantation of a continuous morphine pump device. Twenty-seven patients had intractable cancer pain relating to various malignancies while 3 patients had noncancer-related pain. Table 1 summarizes the types of malignancies as well as the other causes of pain in our 30 patients.

Of the 15 patients on whom the study was based, there were 6 males and 9 females ranging in age from 29 to 83 years, with a mean age of 61 years. As part of our criteria for pump placement, these patients had a life expectancy of greater than a few months and all were unable to control their pain with systemic narcotics at doses that did not cause undesirable side effects. None of these patients were considered candidates for neurosurgical pain relief procedures, such as cor-

Table 1. *Etiology of intractable pain.*

Cancer Related	
Colon	9
Cervix	7
Vulva	2
Breast	2
Ovary	2
Lung	2
Other	3
Noncancer Related	
Herpes Zoster	2
Osteoporosis	1

Table 2. *Implantation considerations.*

Candidate should be free from:

- Cord compression
- Neurogenic pain
- Major depression
- Morphine allergy
- Hepatic failure
- Renal failure
- Severe lung disease
- Significant immobility
- Significant coagulopathy
- Major cerebral pathology

dotomy, because of the bilaterality or other characteristics of the pain; nor did any of them have a known contradiction to pump implantation (Table 2). Patients who had spinal canal obstructions were not considered appropriate because the blockage could potentially interfere with cerebrospinal fluid circulation. Nor were patients accepted whose pain was primarily neurogenic because central neurogenic pain does not respond well to intrathecal morphine. Since one of the goals of delivering spinal opiates via an implantable pump is to enable the patient to enjoy a more normal lifestyle, those individuals with complex medical problems or significant immobility were not considered ideal candidates.

Methods. Medical records were reviewed. It was verified, via operative records and progress notes, that all of the 15 patients had been entered on our prepump protocol, having had a temporary percutaneous epidural catheter placed for 48 hours prior to the implantation of the permanent intrathecal pump. It was confirmed that once the epidural catheter was in place, all patients had been given a 2 mg bolus injection of preservative-free morphine sulfate injection for epidural and intrathecal administration (Duramorph®); this was repeated over the next 48 hours on an "as needed" basis until a subjective relief of pain for at least 12 hours was registered by the patient. Medication records showed a concomitant decrease in the need for systemic narcotics; this confirmed the efficacy of the epidural morphine.

During this trial period, all patients were maintained in a setting conducive to close monitoring, i.e. recovery room, intensive care unit, or step-down unit. Progress notes, nurses' notes, vital sign graphs, and medication records were evaluated for notations pertaining to signs of respiratory depression, nausea, vomiting, pruritus, and urinary retention. After 48 hours, if pain relief had been documented and no significant systemic side effects were noted, the patient was implanted with a permanent INFUSAID® model #400 implantable pump.

In all cases, it was determined that the following surgical procedure for implantation of the pump was instituted: The procedure was done under local anesthesia with sedation. A 14-gauge Touhy® needle was used to thread a silastic catheter through the lumbar space into the thecal sac at the level of the third to fifth vertebrae. Entrance into the sac was confirmed by good flow of cerebrospinal fluid. This catheter then was threaded subcutaneously to a suprafascial pouch that had been developed in the abdominal wall. The pump device then was placed into the pouch and connected to the catheter. The amount of morphine to be delivered to the patient was determined by the concentration of the morphine mixture that was instilled into the 50 ml drug chamber. The formulas for determining this concentration, along with sample calculations, are presented in Table 3. The pump then was refilled with an appropriate morphine mixture at approximately 25-day intervals, or on an "as needed" basis.

The INFUSAID® infusion pump has a drug chamber with a 50 ml capacity, pressurized by a two-phase (gas-liquid) fluorocarbon charging fluid. The internal drug chamber within the metal bellows is filled every two to three weeks by percutaneous injection through a port on the pump surface. Refilling the drug chamber compresses the fluorocarbon charging mixture, more of which then assumes the liquid state. The constant pressure generated then forces the drug mixture out and into the intrathecal space at a constant rate of 2 to 3 ml per 24 hours.

Results. Clinical data on the 15 patients are presented in Table 4. Each of these patients had been on systemic narcotics prior to referral for pump implantation, the average dose (in intravenous morphine equivalents) being 91.6 mg/day with a range of 10 to 240 mg/day. In 13 patients, during the 48 hours after each patient was implanted with a temporary epidural catheter and was given a bolus of 22 mg doses of morphine, a concomitant decrease in the need for systemic narcotics was noted in the records. Two of the patients required continuation of their oral narcotics during this period, but at a significantly reduced frequency. Three of the patients experienced nausea and vomiting during the epidural trial period and one patient was described as experiencing "gastric distress." These symptoms were transient in nature and resolved

spontaneously. There were no instances of respiratory depression, urinary retention, or pruritus.

The average trial dose of epidural morphine was 10.1 mg/day with a range of 4 to 20 mg/day. When compared with the patient's prior narcotic need, this epidural dosage represented a 90 percent average reduction in the amount of systemic morphine for pain relief. As per our protocol, the initial intrathecal dosage was calculated at one-tenth of the effective epidural dose. If this initial pump dosage was ineffective for pain relief, it was supplemented through the side port with a single 2 mg bolus dose. This then was used to recalculate an effective intrathecal dosage. The average initial intrathecal dosage, via the permanent pump, was 4.05 mg/day with a range of 0.68 to 9.6 mg/day. This average was not the expected one-tenth reduction but was closer to half of the epidural dosage.

DISCUSSION

Management of chronic intractable pain due to cancer remains a significant problem for physicians. In patients with advanced metastatic or terminal phase cancer, it is estimated that approximately 71 percent experience severe, unrelenting pain.[1] This amounts to 350,000 Americans and over 3,000,000 patients worldwide.[6,7] Thirty percent of these cancer patients will describe their pain as severe to excruciating.

Most cancer pain is adequately treated with oral or systemic analgesics.[8,9] This armamentarium includes non-narcotic analgesics, nonsteroidal analgesics, a variety of narcotics and steroids, and antidepressants, anxiolytics, major tranquilizers, calcitonin, and luteinizing hormone-releasing hormone agonists. Systemic analgesics, however, remain the cornerstone of cancer pain therapy.

In a significant percentage of patients, the cancer pain is unresponsive to systemic narcotics or responds only at dosages that cause intolerable side effects for the patient and family. These side effects can include insomnia, lethargy, dysphonia, confusion, and hallucinations. Thus, alternatives for relief of chronic cancer pain were needed when

Table 3. ***Dose calculations.****

To determine drug concentration (mg/ml):

Daily dose (mg/day) ÷ pump flow rate (ml/day)

To determine the mg of drug required in the filling syringe:

Drug concentration x pump reservior volume

**Continuous Intraspinal Morphine Analgesia for Relief of Cancer Pain: A Current Review by Dennis W. Coombs, MD,* published by Shiley Infusaid, Inc., 1985.

Wang initiated his studies with intraspinal opiates in 1978.[10] Wang based his work on animal models in which opiates, administered intrathecally, were demonstrated to produce a profound inhibition of the discharge of spinal nociceptive neurons and a resultant elevation in the pain threshold.[11] Significantly, these analgesic doses had no effect on the subject's response to light touch, autonomic outflow, or voluntary motor function. Undesirable side effects were eliminated and, at the same time, good to excellent pain relief was achieved. The area of the spinal cord responsible for this "gating" effect later was traced to the substantia gelatinosa of the dorsal horn gray matter.[12-14] This region contains the bulk of small nociceptive primary afferent terminals.

As human clinical trials progressed, the efficacy of this method of narcotic delivery was confirmed by several groups, and investigations in the 1980s led to the development of totally implantable pump systems for continuous delivery of intraspinal opiates.[15,16] The benefits of this method of pain control, especially significant for the cancer patient, were a reduction in opiate dosage, less narcosis than observed with systemic narcotics, and a delivery method free of external equipment needs and hospitalizations. The patients were found to be more alert, less depressed, and more easily managed at home with only occasional visits to the physician for pump refills.[17]

Many advantages exist with intrathecal delivery of spinal opiates; however, the potential for significant systemic side effects remains. The most significant of these, respiratory depression, is unusual in patients already on large doses of systemic narcotics, it remains a possibility, and dosage titration must be approached cautiously.[18,19] Brazenor's protocols allowed that, even when paced intrathecally, direct pump filling could be undertaken with caution and with close monitoring.[5] Krames advocated the use of a temporary, percutaneous epidural catheter to help determine such factors as patient response to intraspinal opiates, propensity for systemic side effects, and initial dosage of the implanted intrathecal pump.[20]

For our 15 patients, this use of a temporary prepump epidural catheter was deemed the safest and most effective method of procedure. Several important points relative to this protocol became evident from our patient review. First, the percutaneous catheter trial proved a reliable indicator of response to intraspinal opiate therapy. All 15 patients, who initially responded with pain relief from the morphine given via the percutaneous epidural catheter, also achieved satisfactory relief with permanent intrathecal pump implantation; a

Table 4: *Characteristics of patients undergoing intrathecal pump placement.*

Age/ Sex	Lesion Site of Pain	Systemic Medication Dosage in Morphine Equivalent (mg/day)	Epidural Trial Dosage (mg/day)	Initial Pump Dosage (mg/day)
62M	Colon cancer Left hip	216	16	6.00
70F	Pelvic cancer (1° unknown) Pelvic; rectal pain	2	4	0.68
65M	Colon cancer Rectal, sacral pain	240	6	2.00
58M	Colon cancer perineal	10	8	1.36
70F	Rectal cancer coccyx; bilat. buttocks	115	8	1.00
45F	Uterine cancer right lower back; ext.	20	20	9.60
65M	Colon cancer bilat. lower extremity	240	12	3.20
59M	Mesothelioma right shoulder and chest	120	10	6.00
47F	Breast cancer spinal bone pain	30	10	4.00
78M	Prostate cancer lumbosacral; bilat. lower	60	12	6.00
59F	Cervix cancer lumbosacral; right lower ext.	120	10	5.00
29F	Cervix cancer left flank, lower extremity	80	5	8.00
83F	Malignant osteoporosis left thoracic and lumbar spine	97.5	8	2.80
56F	Vulvar cancer vulvar pain; perineal burning	38.4	8	1.20
77F	Bladder cancer pelvic; perineal	14.4	14	4.00

concomitant decrease in the need for systemic narcotics was registered by all patients. Second, the trial via the percutaneous epidural catheter was shown to be a reliable indicator of possible systemic side effects. Although none of our patients experienced serious adverse reactions, we were able to identify minor side effects following administration of the intraspinal morphine. Third, and in many respects most importantly, during this trial period the patient was reassured as to the efficacy of this modality for management of pain.

Retrospectively, our protocol was less useful in providing us with the initial dosage determination for the permanently implanted intrathecal system. The protocol called for giving a bolus to each patient via the percutaneous epidural catheter, with 2 mg of Duramorph®. This then was titrated over the next 48 hours to the appropriate pain-relieving dose. We relied on the pharmacokinetic work by Norberg, and adopted by Penn and others, that an intrathecal dose of approximately 10 percent of the epidural dose would provide equal analgesia.[21] We found that this ultimately proved inaccurate as a formula for determining our patients' initial pain-relieving intrathecal pump dosage. Rather than the reported 10 percent, our patients required an average of 32 percent of the epidural dose with a range of 12 percent to 60 percent. This suggests that 10 percent of the epidural dose was inadequate to meet our patients' needs. Why our patients required greater dosage of intrathecal morphine than expected is unclear; however, this retrospective review demonstrates that while 10 percent of the epidural dosage is a safe starting point for the permanent pump intrathecal dosage, it often is not the pain-relieving dose.

SUMMARY

This retrospective review permits limited conclusions due to the small sample size and the limited control of variables. The temporary prepump, percutaneous epidural catheter trial is a useful component of our protocol. This period provides important information relative to possible side effects and efficacy of pain. The trial does give an estimation for the starting point of the intrathecal dosage but, as we have demonstrated, this is, at times, at a greater dosage than previously had been predicted. We feel that this retrospective review supports the continued use of a prepump trial of epidural morphine prior to permanent intrathecal pump implantation. ■

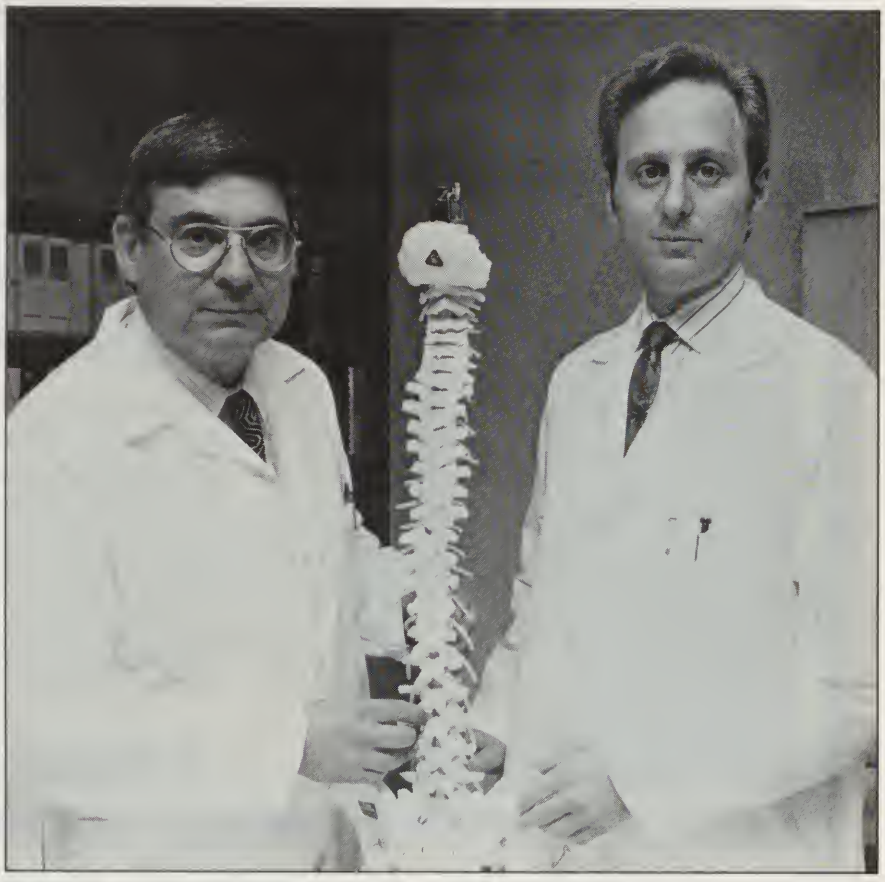


Figure. Dr. Abbott Krieger and Dr. Allen Maniker. © Debra Correale.

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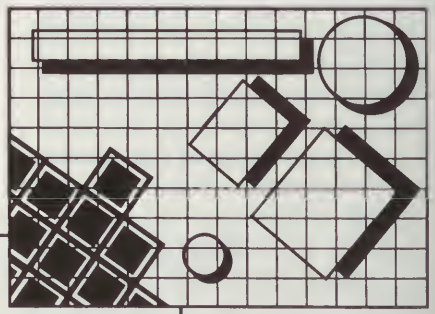
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Position Paper: Health Access New Jersey

Medical Society of New Jersey

The health care system in New Jersey is among the finest in the nation. This MSNJ position paper offers proposals to strengthen the system and to give the best care to all the citizens of New Jersey. The paper encourages a close relationship between government and physicians.

New Jersey is the most densely populated state in the nation. The standard of income and sophistication of our residents rank among the top three states. Our health care system is among the finest. We have over 100 acute care hospitals, and our hospitals average over 300 acute care beds. For the most part, access to care is equitable throughout the state.

The University of Medicine and Dentistry of New Jersey is a nationally recognized medical school. Most areas of our state are within 30 minutes drive of major hospital and physician facilities. New Jersey residents have a variety of choices and immediate access to advanced technology and the finest clinicians in the world.

Beyond our technical capacities is an element of humane concern for all people, and a desire to assure that everyone has access to the health care they need. In New Jersey, medical indigents as well as Medicaid patients have the same access to doctors and hospitals as the insured patient. Over $600 million yearly of hospital indigent patient services are funded by a surcharge on health insurers, while an additional $300 to $500 million of physician services are provided voluntarily, without compensation, by the doctors of New Jersey.

It has been difficult, and is becoming more difficult, for the state and federal governments to properly fund Medicaid, and for providers to deliver care to the uninsured. The current program is institutionally focused and is very expensive, lacking continuity of care, preventive medicine, and the dignity of delivery that our citizens deserve. It is possible that the current $2 billion operating budget can be redirected to enhance both the quality and quantity of services so that hospitals are not used as physicians' offices.

Such a revision would place the Medicaid patient into the mainstream of health care. This would maximize efficiency and permit hospitals to concentrate on those patients whose severity of illness warrants hospital-based care.

Given the background of our environment, it is necessary to note that our current delivery systems, both ambulatory and inpatient, provide consistently high quality and reasonably priced services. A recent study by New Jersey Citizens' Action revealed that the average United States citizen spends $2,251 yearly for health care, while New Jersey residents spent $1,643 per person. New Jersey, therefore, is significantly below the national average, and only marginally ahead of the Canadian average of $1,515 per person. Economic factors, the complexity of society, and concern for the treatment environment differ dramatically between Canada and New Jersey, so the relative parity of these cost figures is remarkable.

While our system has done well, it is under stress. Care for the uninsured and the Medicaid patient must be funded in a more stable and equitable fashion. New Jersey citizens must be assured of access to care in an environment acceptable to patients, physicians, and hospitals. Physicians and hospitals must be allowed to function in an environment that permits professional freedom while requiring public accountability.

HEALTH ACCESS

The major thrust of the Medical Society of New Jersey and the physicians it represents is to search for ways to expand access to care for those persons in New Jersey who have no insurance or who lack adequate health insurance coverage, while seeking ways to reduce the spiraling costs of health care.

It is clear that some segments

Table. *Health cost data—New Jersey.*

$650 million	Uncompensated Hospital Care
$300-500 million	Uncompensated Physician Care
$150 million	Under-reimbursed Physician Care in Medicaid
$400 million	Hospital and Doctor Malpractice Premiums
$ 2 million	Auto Surcharge—Doctors
$ 2.5 million	Auto Surcharge—Medical Inter-Insurance Exchange of New Jersey
$ 2.5 million	Auto Surcharge—Princeton
$250 million	Medicare Undercompensation of Doctors
$ 1.757 billion	
$ 1 billion	(Estimated Defensive Medicine Cost)
$ 2.757 billion	Total
$ 5 million	Malpractice Surcharge—State JUA
$ 2.762 billion	Total

Conclusion: There are $2.762 billion being added to the cost of health care in New Jersey related to governmental policies that force cost shifts to private patients, and the failure of government to address professional liability reform.

of our system in New Jersey need major restructuring. This restructuring needs to be accomplished in a manner that does not jeopardize access to quality care or the strong aspects of our current system.

"Health Access New Jersey" presents a challenge to governmental forces in the state. The challenge is whether this administration is willing to pay for access to care for all those who cannot provide it for themselves. Certain priorities must be considered:

1. Revenues may have to be transferred between or among current programs.
2. New sources of revenue may have to be found.
3. Public support for legislation necessary to bring about concrete changes will have to be developed.

There is a need for statewide dialogue to address these changes and critical issues. The problems facing the New Jersey health care system cannot be solved by any one group—government or the private sector. A collaborative process should be pursued, with government and medicine working together for the best interests of our citizens.

Certain conceptual elements must become governmental policy goals. These include:

1. Ensure that most patients have the ability to choose the physicians, hospitals, and systems of health care that they want and with which they are comfortable.
2. Create incentives to make available new technology.
3. Sustain a medical education system that seeks to attract the best and brightest students, leading them into a rigorous and comprehensive learning process that will assure the public of well-trained physicians in the future.
4. Nurture professional ethics, prudent judgment, and professional freedom in the delivery of health care to the citizens of New Jersey.
5. Take steps to reduce the reasons creating the need for physicians to practice defensive medicine.

HEALTH ACCESS PLAN

To accomplish "Health Access New Jersey," several specific activities are needed.

• *Role of Government*

A. Increase access to care by enacting major Medicaid reforms. It is distressing that Medicaid is so abysmal. New Jersey should assure that all persons of low and poverty income levels are eligible for adequate benefits so that this group is not left without access to needed health care. Perhaps a Medicaid eligibility standard of 185 percent of the federal poverty level could be a goal that will allow for coverage of most uninsured. All basic medical benefits must be covered. There should be no rationing of care nor skimping of funds. Physicians and hospitals should be paid fairly for services rendered to Medicaid patients, at least at the same rate the federal government pays for Medicare patients.

B. Create a state-operated health insurance pool for small employers similar to the state-operated insurance mechanism for temporary disability benefits. The thousands of small employers and their employees would comprise an underwriting pool of tens of thousands that could be effectively and efficiently insured.

C. Increase access to care by creating state level risk pools that would make available coverage for those who are unable to obtain affordable health care insurance. These pools would ensure that no one in New Jersey would be denied health care insurance because of a particular health condition. They also would guarantee continued health care coverage when persons are changing jobs.

D. Reduce health care costs through professional liability reform. This would reduce the practice of defensive medicine. It is estimated that defensive medicine adds approximately 15 to 25 percent to the total health bill. There are estimates that defensive medicine may approach $20 to $30 billion yearly in the United States, and perhaps more than $1 billion per year in New Jersey. Reform should be designed to lower frequency and severity of speculative litigation, while preserving the rights of injured patients.

Areas for a legislative approach include: require a certificate of merit as a prerequisite to file a liability case; adoption of basic medical expert witness criteria; limitation of $250,000 on recovery of noneconomic damages; periodic payment of future awards of damages; and declaring a definite statute of limitations.

E. Develop professional practice parameters to help assure that only high-quality appropriate medical services are provided.

This will impact favorably on quality and cost of medical care. Such parameters would be professionally developed strategies for patient care, developed to assist physicians in clinical decision making.

F. Urge more state, federal, and medical school support for medical education and research. We must increase state grants/scholarships to ease the widespread anxiety among medical students about their ability to finance their medical education. The accumulated debt of many students is overwhelming, and this is due largely to the fact that many students come from middle-to-low income families who cannot make substantial financial contributions to the education of their children.

G. We can reduce health care costs by reducing the administrative cost of health care delivery and excessive paperwork forced onto patients, their families, and their physicians. The frustrations of physicians in dealing with differing managed care requirements of multiple insurance companies and government programs result in increased office costs and interference with the physician/patient relationship.

• *Role of the Medical Community*

A. Encourage health promotion and disease prevention, including healthier lifestyles. We must promote programs that will eliminate smoking, decrease alcoholism and drug abuse, reduce cholesterol, encourage better adolescent health practices, and decrease the spread of AIDS.

B. Encourage physicians to practice with the highest ethical standards. We should encourage all physicians to treat their patients as individuals; to use the best possible judgment in every case regarding quality of care; to inform patients (when possible) of the usual risks, complications, and alternatives regarding health care, and the costs of such care; to treat all patients with courtesy, dignity, respect, compassion, and attention; and to overcome any bias in the treatment of all AIDS patients.

C. Develop standard practice parameters for all specialties of medical practice.

SPECIAL PROBLEMS

A. *Uncompensated Care.*

1. Increase the Medicaid eligibility levels to 185 percent of the federal poverty level so that more persons are covered under Medicaid.

2. Provide state-operated insurance pools so all employers can participate.

3. Eliminating the usual "pre-existing loss" requirement and the waiting period required by insurance companies would allow persons to have continued health care coverage when changing jobs.

B. *Certificate of Need.*

The certificate of need program (CON) should be re-evaluated. Our state has a hospital rate-setting mechanism that makes the CON program in its present form obsolete. Nationally, at least 12 other states have repealed their CON legislation as they developed rate-setting mechanisms. If, however, New Jersey wishes to continue the program, modifications should be studied. Among the points to be considered are: removing the requirement of a CON for diagnostic technology; and in the alternative, raise the entry level for CONs from the current base of $400,000 cost factor to $2 million.

There has been considerable speculation that the governor and the Commission believe that the CON must be extended to physicians to create a level playing field. While MSNJ does not agree with that goal, it understands but does not believe it can be practically or equitably achieved. Hospitals are multimillion dollar corporate conglomerates. They employ hundreds of people and retain batteries of lawyers, accountants, and financial advisers. The current CON system is dominated by hospital interests. Most of the persons in the approval cycle either are directly or indirectly (but very significantly) connected to hospitals.

Certificate of need extension to physician offices clearly interferes with the physicians' ability to exercise their legally franchised right to practice what they in fact have been trained to do. As an example, the radiologist is trained and licensed to practice radiologic services, that may include all forms of imaging. Forcing such a physician to obtain a CON to practice his specialty in a private office setting is an improper intrusion and restriction of the physician's right to practice what he has been licensed to perform.

Further, the restrictive CON process now in place, particularly as it applies to diagnostic services, has fostered the proliferation of private imaging services because of demands for access to such services and the limited access in hospital settings.

Therefore, in the context of a CON for physicians in New Jersey, the following concerns must be addressed:

There must be careful consideration as to when a CON is required. Everything that a doctor does in his office also is done by doctors in hospitals. The point of attachment needs to be selected with such concern so that it does not destroy the opportunity for the private practice of medicine, if we are to avoid a monolithic system.

The decisional apparatus must be patently objective and cannot demonstrate the slightest appearance of impropriety. The current CON apparatus does not meet this test. Hospital interests are evident and controlling. Decisions will need to be insulated from undue influence, and those making the decisions cannot have a direct or indirect interest in the outcome. It is difficult to envision how the current composition of either the SHCC or the HCAB can meet the test of objectivity required. Either a new format or a reconstituted SHCC and/or

HCAB must be used, with the appointees being full-time governmental employees (other than those who duties involve operating hospitals).

Physicians must be granted fair, nondiscriminatory, and equal access to controlled technology. If the state is to apply CONs to the physician community, then the recipient of CONs must be required to permit all physicians within the defined geographic region access to the equipment. If the equipment requires specialty designation or skills, it would be appropriate to require that physicians applying for "use" privileges demonstrate their qualifications.

Application of current reimbursement rules that apply to hospitals granted a CON, that include extraordinary rate relief when the hospital faces bankruptcy in the operation of its services, must be extended to physicians who are subject to the CON process.

The CON process neither has contained costs nor produced maximum utilization of available health dollars. The CON system has been used to direct sophisticated technology to failing urban hospitals in an effort to stabilize their poor financial positions. This activity neither is compatible nor consistent with natural market forces. It has not been successful and is not likely to be successful.

Rather than focus on the CON as a planning method, the state should re-evaluate the concept and consider using a strategic planning model in its place.

C. *DRGs.* This system of payment to hospitals has proved to be inadequate and expensive, and should be eliminated. The federal government reportedly will be abandoning it in the next several years. Other states have more efficient and effective methods to finance hospital care than New Jersey. A study presented to the New Jersey State Department of Health several years ago indicated that the "Share" system was just as effective and less expensive to manage in New Jersey.

A system is needed that is truly prospective and permits rapid decision making on the rate-setting process. Hospitals should not be penalized for making rate review requests. However, the system should truly reward those hospitals that operate efficiently and penalize those that do not.

D. *Medicaid.* The Medicaid program in New Jersey has not provided quality care on a routine basis to recipients. The provider fee schedule is woefully substandard, and the federal Health Care Financing Administration has notified the state government that because of low provider reimbursement and its adverse impact on participation, the program is dangerously close to a declaration of noncompliance.

State administrators have not recognized the flawed approach of the substandard fee schedule and have not corrected it. Instead, they have concentrated for over five years on a managed care or HMO concept that has not been accepted by Medicaid patients or health care providers. What the Medicaid administrators have not recognized is that managed care is not a broad spectrum solution. It will only succeed when there are highly motivated patients, and highly motivated physicians.

The best course for Medicaid is a multifaceted system. A viable fee-for-service program must be offered and does have a place. Fee for service never has been given a chance, and it clearly deserves an opportunity to succeed.

Fee for service with realistic utilization controls provides cost effective, high-quality services and assures access.

Managed care is not a panacea. In those instances where it is used, it must be monitored to assure that underutilization, lack of access, and loss of quality are not occurring.

E. *Physician Self-Referral to Diagnostic Services.* Physician self-referral to diagnostic services in which they hold an economic interest is an important issue being studied on both the state and federal levels.

Certainly if a service is considered essential to a physician's specialty, it should be available through the physician. Cardiologists, for example, must have immediate access to x-ray, EKGs, and certain laboratory tests. Orthopaedists and physiatrists must have x-ray capability, and frequently do and should provide physical therapy, on site, under direct supervision. These instances are not all inclusive, but do demonstrate high-quality, cost-effective medicine.

Physician referrals to diagnostic centers in which they have an interest should be governed by advance disclosures to the patient with an option for the patient to go elsewhere. Hospital staff appointments are of significant economic interest to physicians. Physician referrals to the hospitals where they hold privileges also are subject to potential abuse, and must be carefully monitored.

F. *Medicare Mandated Assignment.* One of the major reasons for the rise in the cost of care is that the group of patients paying for services at regular rates is decreasing in ratio to the indigent, and those covered by Medicare and Medicaid. Senior citizens have pressed for mandatory assignment. Many seniors have significant incomes and assets. It is unfair to the nongovernment program patient to limit the liability of seniors who are well-off. A senior with a $25,000 annual income is far better off than a family of four with an income of $30,000.

Mandated assignment is unnecessary in light of federal law that limits balance billings to the federally approved MAAC level. That level has consistently declined, and was further reduced on January 1, 1991.

SUMMARY

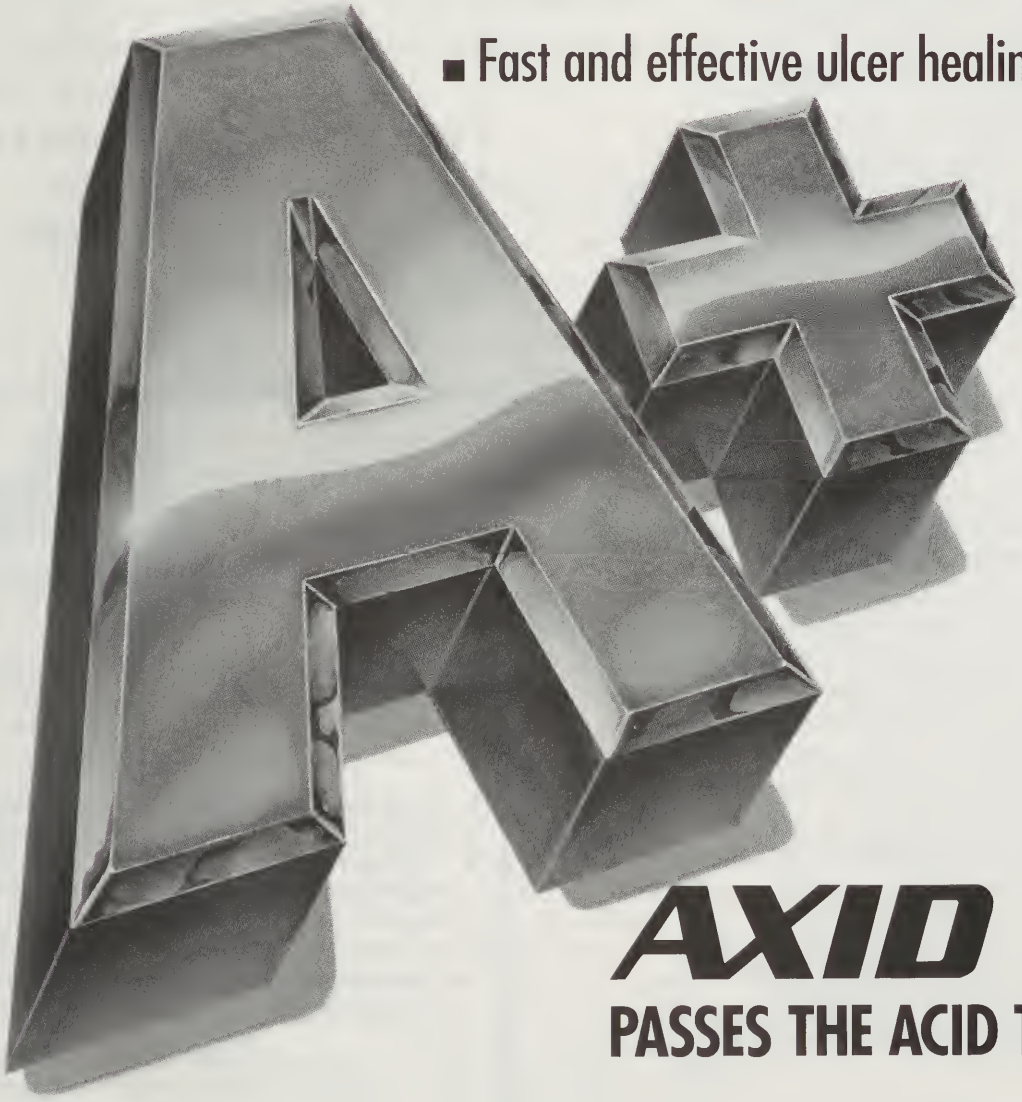
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Drug Interactions – No interactions have been observed with theophylline, chlordiazepoxide, lorazepam, lidocaine, phenytoin, and warfarin. Axid does not inhibit the cytochrome P-450 enzyme system; therefore, drug interactions mediated by inhibition of hepatic metabolism are not expected to occur. In patients given very high doses (3,900 mg) of aspirin daily, increased serum salicylate levels were seen when nizatidine, 150 mg b.i.d., was administered concurrently.

Carcinogenesis, Mutagenesis, Impairment of Fertility – A 2-year oral carcinogenicity study in rats with doses as high as 500 mg/kg/day (about 80 times the recommended daily therapeutic dose) showed no evidence of a carcinogenic effect. There was a dose-related increase in the density of enterochromaffin-like (ECL) cells in the gastric oxyntic mucosa. In a 2-year study in mice, there was no evidence of a carcinogenic effect in male mice, although hyperplastic nodules of the liver were increased in the high-dose males as compared with placebo. Female mice given the high dose of Axid (2,000 mg/kg/day, about 330 times the human dose) showed marginally statistically significant increases in hepatic carcinoma and hepatic nodular hyperplasia with no numerical increase seen in any of the other dose groups. The rate of hepatic carcinoma in the high-dose animals was within the historical control limits seen for the strain of mice used. The female mice were given a dose larger than the maximum tolerated dose, as indicated by excessive (30%) weight decrement as compared with concurrent controls and evidence of mild liver injury (transaminase elevations). The occurrence of a marginal finding at high dose only in animals given an excessive and somewhat hepatotoxic dose, with no evidence of a carcinogenic effect in rats, male mice, and female mice (given up to 360 mg/kg/day, about 60 times the human dose), and a negative mutagenicity battery are not considered evidence of a carcinogenic potential for Axid.

Axid was not mutagenic in a battery of tests performed to evaluate its potential genetic toxicity, including bacterial mutation tests, unscheduled DNA synthesis, sister chromatid exchange, mouse lymphoma assay, chromosome aberration tests, and a micronucleus test.

In a 2-generation, perinatal and postnatal fertility study in rats, doses of nizatidine up to 650 mg/kg/day produced no adverse effects on the reproductive performance of parental animals or their progeny.

Pregnancy – Teratogenic Effects – Pregnancy Category C – Oral reproduction studies in rats at doses up to 300 times the human dose and in Dutch Belted rabbits at doses up to 55 times the human dose revealed no evidence of impaired fertility or teratogenic effect; but, at a dose equivalent to 300 times the human dose, treated rabbits had abortions, decreased number of live fetuses, and depressed fetal weights. On intravenous administration to pregnant New Zealand White rabbits, nizatidine at 20 mg/kg produced cardiac enlargement, coarctation of the aortic arch, and cutaneous edema in 1 fetus, and at 50 mg/kg, it produced ventricular anomaly, distended abdomen, spina bifida, hydrocephaly, and enlarged heart in 1 fetus. There are, however, no adequate and well-controlled studies in pregnant women. It is also not known whether nizatidine can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Nizatidine should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers – Studies in lactating women have shown that 0.1% of an oral dose is secreted in human milk in proportion to plasma concentrations. Because of growth depression in pups reared by treated lactating rats, a decision should be made whether to discontinue nursing or the drug, taking into account the importance of the drug to the mother.

Pediatric Use – Safety and effectiveness in children have not been established.

Use in Elderly Patients – Healing rates in elderly patients were similar to those in younger age groups as were the rates of adverse events and laboratory test abnormalities. Age alone may not be an important factor in the disposition of nizatidine. Elderly patients may have reduced renal function.

Adverse Reactions: Clinical trials of varying durations included almost 5,000 patients. Among the more common adverse events in domestic placebo-controlled trials of over 1,900 nizatidine patients and over 1,300 on placebo, sweating (1% vs 0.2%), urticaria (0.5% vs <0.01%), and somnolence (2.4% vs 1.3%) were significantly more common with nizatidine. It was not possible to determine whether a variety of less common events were due to the drug.

Hepatic – Hepatocellular injury (elevated liver enzyme tests or alkaline phosphatase) possibly or probably related to nizatidine occurred in some patients. In some cases, there was marked elevation (>500 IU/L) in SGOT or SGPT and, in a single instance, SGPT was >2,000 IU/L. The incidence of elevated liver enzymes overall and elevations of up to 3 times the upper limit of normal, however, did not significantly differ from that in placebo patients. All abnormalities were reversible after discontinuation of Axid. Since market introduction, hepatitis and jaundice have been reported. Rare cases of cholestatic or mixed hepatocellular and cholestatic injury with jaundice have been reported with reversal of the abnormalities after discontinuation of Axid.

Cardiovascular – In clinical pharmacology studies, short episodes of asymptomatic ventricular tachycardia occurred in 2 individuals administered Axid and in 3 untreated subjects.

CNS – Rare cases of reversible mental confusion have been reported.

Endocrine – Clinical pharmacology studies and controlled clinical trials showed no evidence of antiandrogenic activity due to nizatidine. Impotence and decreased libido were reported with equal frequency by patients on nizatidine and those on placebo. Gynecomastia has been reported rarely.

Hematologic – Fatal thrombocytopenia was reported in a patient treated with nizatidine and another H_2-receptor antagonist. This patient had previously experienced thrombocytopenia while taking other drugs. Rare cases of thrombocytopenic purpura have been reported.

Integumental – Sweating and urticaria were reported significantly more frequently in nizatidine- than in placebo-treated patients. Rash and exfoliative dermatitis were also reported.

Hypersensitivity – As with other H_2-receptor antagonists, rare cases of anaphylaxis following nizatidine administration have been reported. Rare episodes of hypersensitivity reactions (eg, bronchospasm, laryngeal edema, rash, and eosinophilia) have been reported.

Other – Hyperuricemia unassociated with gout or nephrolithiasis was reported. Eosinophilia, fever, and nausea related to nizatidine have been reported.

Overdosage: Overdoses of Axid have been reported rarely. If overdosage occurs, activated charcoal, emesis, or lavage should be considered along with clinical monitoring and supportive therapy. Renal dialysis does not substantially increase clearance of nizatidine due to its large volume of distribution.

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Chronic Steroid Dependent Asthma and Pulmonary Function

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The authors followed 84 asthma clinic patients, with an average age of 49 years, for 12 years. Pulmonary function studies consisting of forced expiratory volume in one second and forced vital capacity were performed upon initial evaluation and quarterly re-evaluation.

There is a paucity of information concerning the natural history of adult asthmatics and the chronic effects of asthma on pulmonary function. In addition, the chronic effects of maintenance therapy, utilizing oral and inhaled glucocorticoids and beta agonists, need to be identified and correlated with changes in pulmonary function.

Eighty-four patients from the asthma clinic at Saint Michael's Medical Center were prospectively followed for 12 years. Pulmonary function studies consisting of forced expiratory volume in one second (FEV1) and forced vital capacity (FVC) were performed upon initial evaluation and quarterly re-evaluation.

It was the intent of this study to elaborate on the course of 84 patients with steroid dependent asthma, and identify and characterize those risk factors that lead to a greater degree of functional pulmonary deterioration.

METHODS AND MATERIALS

In 1978, 96 patients were referred to the Asthma Clinic at Saint Michael's Medical Center, a tertiary center for evaluation of recurrent asthma. The patients had been hospitalized an average of 2.6 times for asthma within the last two years, and the previous year they had attended emergency rooms 3.6 times. There were 58 female patients and 38 male patients with an average age of 49 years; 25 of 96 patients were smokers. The average FVC was 90 percent of predicted and FEV was 73 percent of predicted. All patients demonstrated reductions in peak flow, FEV1 and FVC of below 40 percent of predicted during acute episodes when seen in emergency room facilities. Reductions below 25 percent of predicted led to mandatory hospitalizations. All patients had at least 20 percent reversibility with bronchodilator therapy or following a 20 mg course of oral prednisone. Each patient performed a sitting forced vital capacity. Standardized medical histories and physical examinations were performed. Emphasis on presenting symptoms, allergies, ASA sensitivity, nasal polyps, duration of asthma, urticaria, eczema, migraines, and tobacco use were elicited. History of allergic rhinitis, family history for atopy, prior medications, hospitalizations, emergency room visits, and complications of medication also were obtained. All patients were re-evaluated quarterly; most patients were evaluated more frequently, with repeat weight, blood pressure, physical examinations, and FEV1 and FVC. Eighty-four patients completed 12 years of evaluation. All were steroid dependent. Five patients failed to keep appointments and were lost to followup. Seven patients died: 4 patients died as a result of fatal asthma and 3 patients died of metastatic colon, esophageal, and bladder carcinoma, respectively. The ages of those who died of asthma were 34, 36, 42, and 47; 3 patients were African-American and 1 patient was Hispanic. There were no smokers in the group. The 3 patients who died of metastatic carcinoma were 62, 71, and 78 years of age. Of the 4 patients who died of fatal asthma, all were on systemic steroids consisting of 15 mg per day of oral prednisone, and inhaled triamcinolone or beclomethasone. These patients had multiple previous hospital admissions and multiple episodes requiring intubation and critical care monitoring. Despite corticosteroid therapy, these patients continued to have intermittent severe episodes of asthma. Interestingly, 3 of the 4 patients had been diagnosed as having depressive illness. To our knowledge, all 4 patients adhered strictly to medication regimens provided under our direction.

The characteristics of the 84 patients are found in Table 1. All

Table 1. *Characteristics of 84 patients at initial evaluation.*

Black	39
White	32
Hispanic	13
Male	28
Female	56
Smokers	24
Average Age	49.1 years
Steroid Use	
Oral	47
Inhaled	84
Beta Agonist	84
Hospitalizations	2.4/year
ER Room Visits	3.6/year
Initial FEV1	2.34 Liter (73% of predicted)
Initial FVC	3.2 Liter (90% of predicted)
Theophylline	84/84
Duration of Asthma on Initial Visit	7.2 years

84 patients were steroid dependent and considered high-risk asthmatics. The incidence of steroid-related side effects was published previously.[1] All patients were maintained on the lowest dose of oral and inhaled steroids necessary to achieve maximum FEV1. The average daily dose of prednisone was 8.0 mg. Forty-seven of the 84 patients required concomitant oral and inhaled steroids. There were 28 male patients and 56 female, and 24 patients were smokers, both current and former smokers.

Eighty-four patients, when first seen, were taking theophylline derivatives and inhaled B agonists. Forty-seven patients were treated with oral steroids at the time of evaluation.

All patients had been discharged from hospital care and had received parenteral steroids, theophylline, and inhaled B agonists. Twenty-six of 84 patients had at least one episode of near fatal asthma documented by either intubation, reduction in peak expiratory flow less than 75 liters/min, or the presence of hypoxemia in the face of hypercapnia. Of the 24 patients with near fatal asthma, there were 62 intubations and mechanical ventilatory support. All patients were maintained on inhaled steroids consisting of beclomethasone or triamcinolone. Discontinuation of steroids either voluntarily or as directed resulted in recurrent asthma requiring reinstitution of medications.

To insure the probability of obtaining the most accurate data and to exclude the possibility of acute exacerbation of bronchospasm having an effect on measurable primary function, maximum achievable values during the initial year of evaluation as well as the final year of followup were utilized.

Patients were divided into two groups (Table 2). Group A patients were categorized by a decline in FEV1 and FVC of greater than 20 percent of predicted. Group B were those patients who experienced less than a 20 percent of predicted decline in FEV1 and FVC over 12 years.

RESULTS

Group A consisted of 12 patients (14 percent) who were found to exhibit loss of FEV1 and FVC greater than 20 percent of predicted. This group was predominantly female (83 percent) and older (33 percent were older than 60 years of age). Of this group, 42 percent were smokers and had abnormal radiographs of the chest (50 percent). The group had a strong family history of asthma (42 percent), but an infrequent history of allergic disorders such as eczema allergic rhinitis, migraines, and aspiring sensitivity. A high incidence of concomitant medical disorders were present in this group, and 25 percent had diabetes mellitus and degenerative arthritis. Eight percent had systemic vasculitis.

Group B consisted of 72 patients (86 percent) who failed to exhibit any significant loss of function over 12 years. This group remained within 80 percent or more of predicted FEV1 and FVC. Sixty-four percent were female and only 18 percent were older than 60 years of age. Nineteen patients (26 percent) were smokers and 41 percent had abnormal radiographs of the chest. In this group, 52 percent had a strong history of allergic rhinitis and 51 percent had a family history of asthma. Over half of the patients (51 percent) had concomitant medical disorders. Interestingly, Group B patients were hospitalized more frequently. Statistical comparison between the groups demonstrated that those patients with reduced lung function were older females with strong family histories of asthma and few allergic manifestations, while those who experienced little reduction in lung function tended to be younger and all had a greater history of allergic manifestation such as rhinitis and nasal polyps.

Little statistical difference could be found between Group A and Group B regarding tobacco use, radiograph abnormalities, concomitant medical illness, and steroid complications. Both groups had similar duration of asthma.

DISCUSSION

There have been few detailed longitudinal studies of lung function on steroid dependent asthmatics.[2] We chose to measure FEV1 and FVC as the indices most sensitive to changes in flow rates.[3] We studied 84 high-risk steroid dependent asthmatics over a 12-year period. Seventy-two of the 84 patients (85 percent) maintained normal FEV1 and FVC while on oral or inhaled steroid therapy. However, 12 of the 84 patients (14 percent) exhibited declines of FEV1 and FVC of greater than 20 percent of predicted. The differences between the two groups suggest older patients tend to lose greater function than younger asthmatics and a history of allergic manifestations such as seasonal rhinitis, eczema, and family history of atopy tend to be associated with less decline of function. Poukkula studied women with chronic asthma and measured the diffusing capacity for carbon monoxide (DLCO) and found no deterioration with time. However, the authors did find FEV1 values as a percentage of predicted fell from 89 percent between the ages 25 and 34, 73 percent between the ages of 55 and 64, and 63 percent over the age of 65. The authors included patients with emphysema and did not attempt to demonstrate a reversible obstructive component in all patients.[4] The results are similar to ours and suggest that older patients were more likely to suffer decline in flow with time.

Turner-Warnick reported that some asthmatics develop an irreversible component of airflow limitation, yet because of the absence of longitudinal studies, its prevalence is difficult to establish.[5] Tschopp studied outpatients with nonsteroid dependent asthma and measured peak flow three times per day for six months. He found several patients failed to reach predicted normal values, and noted a correlation between airflow limitations and duration of asthma as well as the age of their patient studies.[6] We found no statistical difference in the duration of asthma in those patients who maintained normal lung function. However, we did note a significant correlation between those patients with functional reductions and age. Brown noted reduced airflow in older patients with asthma and found no relationship with a smoking history.[7] Forty-one percent of patients in our study who demonstrated increased loss of airflow had significant smoking histories, yet 21 percent of those with normal airflow also used tobacco. The mechanism of irreversible airflow limitations seen in 14 percent of our patients is unclear. The decline in flow rates was gradual and steady over a long period of time in the majority, but in two patients there was an abrupt loss following an acute exacerbation without return to previous levels. Turner-Warnick suggested that some patients with asthma have impaired clearance resulting in sputum retention and obstruction that further impairs clearance.[5] While smoking is associated with increased sputum production, a relationship between smoking and irreversible airflow limitation could not be identified in our patients. We found that once asthmatic patients developed irreversible airflow limitation, loss of function was progressive, and resistant to higher doses of oral and inhaled steroids. Turner-Warnick described some patients with irreversible airflow limitations to B agonists and steroids who respond partially to atropine.[5] To our knowledge, there is no histologic data available on such patients to delineate where airway obstruction exists. The majority of our steroid-treated asthmatics had little functional loss over the observed period, supporting current theory that asthma may be a disorder of airway inflammation. There is little doubt that corticosteroid therapy represents the most effective form of therapy for managing chronic asthma. The majority of our patients were able to lead normal lives, required few hospitalizations, and maintained normal airflow. Our study further demonstrates that lung function can be preserved over time with few serious side effects.[1] The use of corticosteroids for the treatment of asthma first was reported by

Table 2. *Characteristics of Group A and Group B.*

	Group A 12 Patients (14%)	Group B 72 Patients (86%)
Age	52	48.5
Male	2 (16%)	26 (64%)
Female	10 (83%)	46 (64%)
Age > 60	4 (33%)	13 (18%)
Aspirin Sensitive	0 (0)	5 (7%)
Nasal Polyps	0 (0)	7 (10%)
Seasonal Rhinitis or Chronic Rhinitis	4 (33%)	38 (52%)
Family History of Asthma	5 (41%)	37 (51%)
Abnormal Chest Radiograph	6 (50%)	30 (41%)
Tobacco Use	5 (41%)	19 (26%)
Complications of Therapy	2 (16%)	9 (12%)
Concomitant Medical Disorder	8 (66%)	37 (51%)
Average Duration of Asthma	5.6 years	7.5 years

Solis-Cohen when he used an "adrenal substance." The active agent was thought to represent cortisone or compound F.[8] Ellvl-Micallif suggested that gluococorticosteroids act by controlling the rate of synthesis of regulatory proteins that have anti-phospholipase A2 (PLA 2) activity. These proteins have been termed lipocortins that can bind to and inactivate PLA 2 preventing the enzymatic cleavage of arachidonic acid.[9] Lipocortins inhibit the formation of prostaglandins via the cycloxygenase pathway and may interfere with synthesis of platelet-activating factor.[10] Therefore, glucocorticoids via lipocortins may constitute an endogenous control of the inflammatory response.[10] It has been suggested that airway inflammation may be the cause of asthma and, if inflammation is severe enough, chronic airway obstruction is likely to persist.[10,11]

SUMMARY

The majority of chronic asthmatics can maintain normal flow rates while on chronic topical and oral corticosteroids giving further credence to the theory that inflammation represents the alleged pathogenetic mechanism for asthma. ■

Drs. Miller, Arno, Klukowicz, and Adelman are affiliated with the Department of Pulmonary Medicine, Seton Hall School for Graduate Medical Education, Elizabeth. Dr. Safirstein is director of pulmonary medicine, Saint Michael's Medical Center. Dr. Khan is director of pulmonary medicine, Saint Joseph's Hospital and Medical Center, Paterson. The paper was submitted in June 1991 and accepted in August 1991. Requests for reprints may be addressed to Dr. Safirstein, Saint Michael's Medical Center, 268 Martin Luther King Jr. Blvd., Newark, NJ 07102.

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Dentistry's Role in Treating Sleep Apnea and Snoring

Herbert Paskow, DDS
Sanford Paskow, DDS

Dental appliances have a place in the treatment of loud snoring and obstructive sleep apnea (OSA), and may be indicated for those patients who cannot tolerate continuous positive air pressure ventilation. Physicians and dentists must work together for the health, comfort, and well-being of patients.

Obstructive sleep apnea (OSA) is a common clinical disorder that can be life threatening.[1,2] Symptoms associated with OSA include: excessive daytime sleepiness, hypoxemia, hypercapnia, hypertension, and pulmonary heart disease.[3] Sleep is punctuated by loud snoring, periods of breath holding followed by gasps and/or snorting, and then regular breathing. These episodes occur from occlusion of the pharynx over an area extending from the base of the tongue inferiorly to the uvula and soft palate superiorly.[4] Treatment generally has involved increasing the airway passage through the pharynx by weight loss, medication, nasotracheal intubation,[5,6] continuous positive air pressure (CPAP) ventilation,[7] surgical correction of obstructive lesions, surgical advancement of the mandible,[8] uvulopalatopharyngoplasty (UPPP),[9] and tracheostomy.[10] Dental appliances are being used and evaluated as alternative treatment modalities for OSA and snore control to spare the inconveniences associated with surgery and to improve patient comfort of nonsurgical methods (Figures 1 to 10).

The rationale of treating OSA is to eliminate the obstruction or to increase airway space. This usually can be accomplished by moving and holding the base of the tongue forward or positioning the mandible. Newly developed dental appliances are intended to accomplish one or both of these functions. The tongue-retaining device (TRD) increases the pharyngeal breathing area by pulling and holding the base of the tongue upward and forward, the tip of the tongue being locked into a bubble-like compartment between the patient's lips (Figure 1).[11] The nocturnal airway patency appliance (NAPA) locks the mandible in an anterior position and allows forward tongue positioning and mouth breathing (Figure 2).[12] The Equalizer, the Herbst, and the Snore Guard reposition the lower jaw slightly forward and downward and allow mouth breathing (Figures 4, 5, 6, and 7).[13-15] All of these appliances are removable and most are custom made. Additional appliances, claiming high percentage successes in treating OSA and snoring also are available.[16]

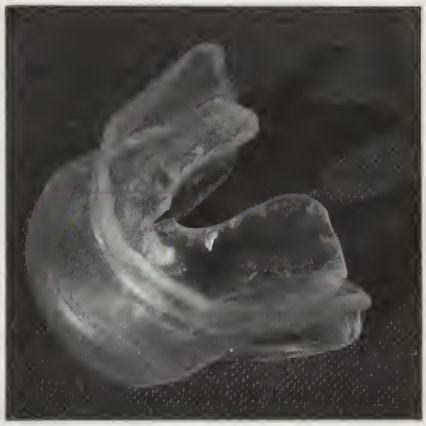


Figure 1. Samelson Tongue-Retaining Device (TRD).

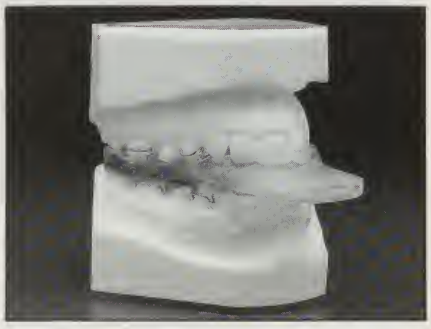


Figure 2. George NAPA Appliance. Photograph courtesy of Great Lakes Orthodontics, Tonawanda, New York.



Figure 3. Tepper TOPS Appliance. Photograph courtesy of Great Lakes Orthodontics, Tonawanda, New York.



Figure 4. Meade Snore Guard appliance.

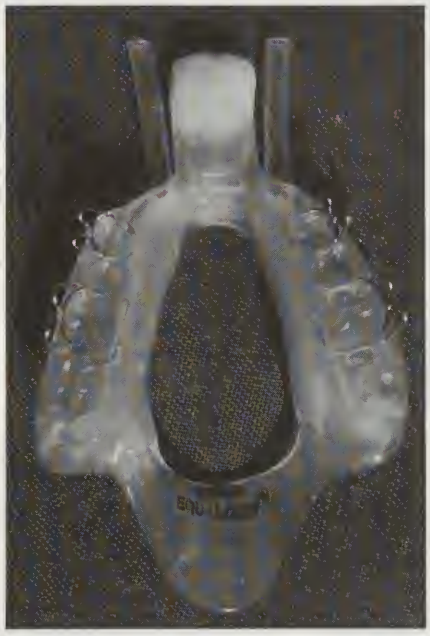


Figure 5. Glaze Equalizer appliance.

The snoring sound is produced by the uvula, soft palate, and base of the tongue vibrating against the posterior wall of the pharynx. Such noise levels can be barely audible but have been known to approach 90 decibels. Loud snoring can cause the snorer humiliation, embarrassment, and emotional distress. Family members, subjected to such a phenomenon, can be affected physically and mentally; because they may be awake much of the night, family members can experience excessive daytime sleepiness (EDS), lack of energy, and low resistance to disease. Loud snoring alone also has been known to awaken the snorer throughout the night, deteriorate marriages, and affect job security. When snoring becomes disruptive to the life of the individual or to family members, medical advice should be sought.[17]



Figure 6. Herbst appliance, side view. Photographs courtesy of Space Maintainers Laboratory, Van Nuys, California.

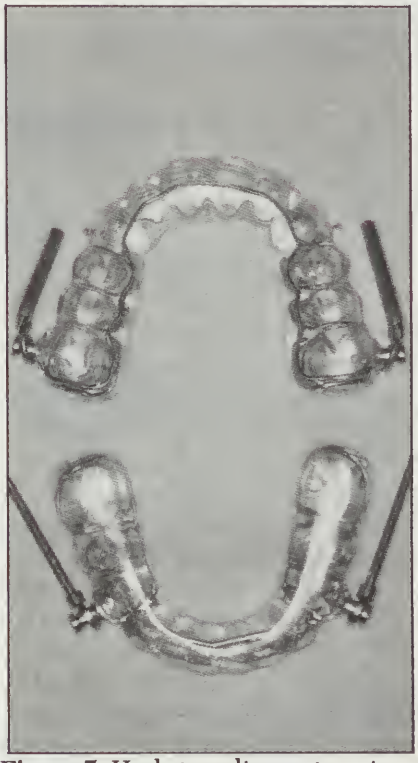


Figure 7. Herbst appliance, top view.

Two individually made appliances prescribed for just snore control are the anterior labial shield device[18] and the soft palate stabilizing and lifting appliance.[19,20] The first device encourages nasal breathing; the soft palate stabilizing and lifting appliance helps keep the soft palate and uvula from vibrating. Since gagging often is a problem for those patients receiving these fixed and adjustable soft palate lifters (ASPLs), palate desensitization exercises usually are recommended before presentation (Figures 8 and 9).[21]

Physicians should recommend and prescribe the appliance of choice for their patient. The dentist must take a thorough medicodental history and perform a clinical examination of the patient's mouth and oropharynx. An overnight polysomnographic sleep test should be performed and evaluated by a trained polysomnographer; the patient then should be informed of the problem with an explanation of available treatment options. Periodic recall visits and telephone calls are necessary after treatment is administered; followup polysomnograms are indicated, while appliances are being worn, for all patients.[22]

CONCLUSION

An attempt has been made to make the reader more aware of OSA and the snoring phenomenon, and to inform the physician of the more recent dental devices being utilized as viable treatment modalities. The importance of physicians working in harmony with dentists is stressed, since the patient's health, comfort, and well being are prime objectives for all concerned. ■



Figure 8. Paskow Adjustable Soft Palate Lifter (ASPL), in the retracted position. Courtesy of Ortho Publications, Westfield, New Jersey.



Figure 9. Paskow Adjustable Soft Palate Lifter (ASPL), in the extended position. Courtesy of Ortho Publications, Westfield, New Jersey.



Figure 10. Gardy Tongue Locking Device.

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Urinalysis for the Private Office Laboratory

Kathleen Voldish, CLA (ASCP)

Urinalysis is the most frequently ordered test performed in the physician office laboratory. Quality control programs must be a part of every urinalysis ordered in the office laboratory. Quality control will assure the test will yield reliable information.

Our physician office laboratory (POL) performs urinalysis in the office. What guidelines need to be followed for quality assurance?

Urinalysis is the most frequently ordered test performed in office laboratories. Quality control (QC) programs must be part of every test ordered in a POL. A complete QC program assures that the test will yield reliable information. This should include an internal QC program, such as daily control stick checks, and an external QC, such as unknown samples supplied from a proficiency testing program. This combination is the best way to monitor both accuracy and precision.

A POL procedure manual should include all tests performed on urine. Procedures should be written according to the National Committee for Clinical Laboratory Standards guidelines. Procedure manuals help standardize the testing procedures if one or more people do the testing. By following the same guidelines for every specimen, the accuracy and reproducibility are enhanced. The manual should include:

1. Patient instruction for proper collection. These instructions can be copied and given to the patient to assure a clean and freshly voided specimen. Special instructions for pediatric collection also may be necessary.
2. Timing considerations from collection to testing and provisions for preserving specimens that cannot be processed within an acceptable time period.
3. Types of acceptable collection containers.
4. Instructions and descriptions of all tests performed. This should include methodology and derivation of results. The manufacturer insert should contain this information.
5. Expected values and panic values.
6. Backup tests for abnormal or questionable results.
7. Care and storage of reagents and control sticks.
8. Instructions for the preparation of control sticks and a log to record control results. Records should be retained for two years.
9. Safety information associated with the handling of reagents, controls, and specimens, and how to properly dispose of specimens when finished testing.
10. Instructions for preparing slides for microscopic examination, including the correct centrifuge time and speed.

Reference materials such as atlases and charts should be available to assist in microscopic identification of sediment.

The physician or laboratory director should review the procedure manual annually; it should be dated and initialed. Control logs should be reviewed weekly or monthly depending on frequency and quantity of tests performed. All results should be filed or charted in an organized manner and retained in the laboratory. A copy of the results should be recorded in the patient's chart.

What are some common sources of error a POL might make when performing urinalysis?

Test strips and control strips degrade quickly from moisture; never remove the package of desiccating material from the jar. Replace the cap tightly after each use. Test strips also are sensitive to excessive heat and light exposure. Never touch the reagent area of the stick with your fingers—this can alter the chemical reaction. Always discard strips after expiration date. The only reliable way to determine if the test strips are functioning properly is to regularly use control test sticks that have known concentrations of the test analytes.

Timing is critical. If the test strip is read late, the results can be overestimated. If the test strip

is read too quickly, the results can be underestimated. Good natural light or fluorescent light is essential to the proper reading of the colors.

Specimens always should be fresh and properly collected. Preservative tablets should be used when testing is not performed shortly after collection, and specimens should be refrigerated. Specimens improperly labeled should be discarded as well as any specimens left at room temperature. Collection containers must be free of any detergent contaminants that can alter the chemical reactions.

Always re-mix the specimen before testing. A dipstick should be quickly dipped in specimen—making sure that all reagent areas have been wet. Never leave a dipstick in urine as this will diminish the chemical reaction. Drain dipstick briefly against the side of container then place horizontally so that the urine and chemicals do not pass from one block to the adjacent one. Never lay a test strip directly on the table surface.

Recording results carefully is an obvious but important step.

The microscopic examination should reflect the results from the test strip. Discrepancies should be recognized and acted upon. Centrifuge at 2,500 rpm for five minutes. After centrifuging the urine, discard the supernatant and resuspend the sediment by gentle agitation. Slides and cover slips should be free of scratches and clean. Do not flood the slide—one drop is sufficient. Always use a cover slip. Be careful not to trap air bubbles that could be mistaken for lipids. Read at least ten fields under 40X high-dry objective. Lastly, the person responsible for reading and reporting the results should be sufficiently trained and able to identify cells, crystals, organisms, and casts in urine sediment.

There are a number of factors that can cause erroneous results that stem from patient medications or substances. The most common interfering substance is ascorbic acid (vitamin C). In detectable concentrations, it can alter the glucose, bilirubin, blood, nitrite, and leukocyte reading. Dyes excreted in urine from x-ray contrast materials, vitamins, and medications such as chemotherapy drugs also can alter the color reading. A list of interfering substances can be found in a textbook and often the interfering substances are listed on manufacturer inserts. The technician must be aware of substances that can inhibit, intensify, or invalidate findings. ■

Ms. Voldish is a registered technologist and laboratory manager, and director of POL Consultants. Requests for information can be addressed to Ms. Voldish, 1150 Concord Drive, Haddonfield, NJ 08033.



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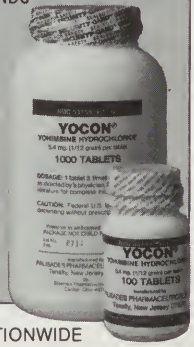
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Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.[1,2] Also dizziness, headache, skin flushing reported when used orally.[1,3]

Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.[1,3,4] 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to ½ tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.[3]

How Supplied: Oral tablets of Yocon® 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.



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Medical History: Health Care Crusader, Florence C. Child

Geraldine R. Hutner, MA

In January 1924, Florence Chapman Child, MD, was elected to membership in the Mercer County Medical Society. Against great odds, she made her mark in medicine as one of the first women members of the County Society. Dr. Child will be remembered for her dedication to public health.

Five physicians from Mercer County assembled on May 23, 1848, to organize a county medical society.[1] The group met on a regular basis with the hopes of establishing an organization devoted to the exchange of medical ideas and case reports. Membership in the Society grew at a slow but steady pace.

On December 10, 1907, the 73-member, all-male society inducted its first woman member, S. Mabel Grier, MD.[2] But Dr. Grier left New Jersey in 1909; the following year, Sara Foulks, MD, and Lilla Ridout, MD, were admitted to the Society. But again, Drs. Foulks and Ridout maintained memberships for only a few years, as they relocated to other states.

In January 1924, Florence C. Child, MD, was elected to membership, and against great odds, remained in Mercer County to make her mark in medicine.

EARLY YEARS/EDUCATION

Born in Philadelphia in 1883, Florence Chapman Child was of Quaker stock.[3] She was educated at the Agnes Irwin School in Philadelphia. It was recalled that "as a tiny child playing with her dolls in the nursery of her home, she first indicated her admiration for the medical profession by naming her toy family always with the prefix doctor. To her they were always "Dr. So and So" and never Helen, Grace, or Mabel."[4]

Florence received her college degree from Bryn Mawr College, Pennsylvania, in 1905.[3] In 1909, she was awarded her medical degree from Johns Hopkins University School of Medicine, Baltimore.[4]

Dr. Child completed an internship at Syracuse General Hospital for Women and Children, New York, in 1909, specializing in obstetrics and gynecology. The following year she moved to New York City and was affiliated with Dr. Holt's Children's Sanitorium. That year, 1910, she received medical licenses to practice in New Jersey, New York, and Pennsylvania.[3] In 1911, Dr. Child interned at Babies' Hospital.[5]

Florence's younger sister, Dorothy, also attended the Agnes Irwin School. Dorothy followed in her sister's footsteps; she graduated Bryn Mawr College in 1910; graduated Johns Hopkins University School of Medicine in 1914; served as special assistant, Division of Medical Inspection of Public Schools in Philadelphia; received a doctorate in public health from the University of Pennsylvania; and was employed as chief, Division of Child Health, State Department of Health in Harrisburg, and medical inspector for the Philadelphia public schools. Dorothy died on September 27, 1941, following a yacht explosion off Maryland's eastern shore.

CHOSEN PRACTICE

Dr. Child returned to her hometown in 1912, and was a school medical inspector from 1913 to 1915; from 1915 to 1917 she served as medical inspector for the Division of Child Hygiene, Bureau of Health, Department of Health and Charities. While maintaining a private practice, she also was director of the children's clinic at Jewish Hospital Dispensary (1914 to 1917), and was affiliated with the Kensington Dispensary for Treatment of Tuberculosis (1913 to 1917).[5]

RED CROSS EXPERIENCE

When the United States declared war in spring 1917, Dr. Child went to work for the Red Cross. As a civilian, she performed relief work overseas for 19 months in Evian-les-Bains, France:[5] "At first she was in charge of a children's hospital near the Swiss border, and her little charges were the children of the men and women of France who had been taken prisoners

when the first occupation of the country took place. Many of the little folk were in pitiful condition, and it was the duty of Dr. Child and her corps of workers to nurse back to health the faint spark of life. . . . Later she was stationed in Havre were she was again in charge of a children's hospital. While there, she established health centers and her work was so commendable that a number of decorations were accorded her in recognition of her devoted service."[4] Dr. Child was awarded two decorations from the French government as well as the Red Cross Medal for her two years of service.

RETURNING HOME

After her service, Dr. Child returned to her hometown, 5023 McKean Avenue, Germantown, Philadelphia, to work with the Bureau of Health; she was responsible for school medical inspection and child hygiene. While working for the Bureau of Health in Philadelphia, Dr. Child completed a special public health program and was awarded a doctorate in public health from the University of Pennsylvania.

In 1920, Dr. Child moved her home/office to 924 West State Street, Trenton. Two years later, Dr. Child relocated her office to 317 City Hall, where she remained until 1932.[2]

WORKING IN NEW JERSEY

Dr. Child was very active with the Trenton Department of Health. When she moved to Trenton in November 1920, she became chief, Division of School Medical Inspection and Welfare Nursing, Bureau of Health, with the Department of Public Safety. And she took her job seriously: "She started right in to put over a thoroughly up-to-date system of child hygiene work, which covers the entire city. There are 11 assistants in her division, including the dispensary and tuberculosis nurses. . . . Four clinics have been established in four different sections of the city."[4]

Dr. Child especially was proud of the reduction in infant mortality during her tenure with the Department of Health.[4] Dr. Child brought her message to her physician associates on December 9, 1926, when she and her colleagues from the Department of Health attended a meeting of the



Figure. Florence C. Child, MD. © The Alan Mason Chesney Medical Archives of the Johns Hopkins Medical Institutions.

Mercer County Medical Society, held at the Carteret Club in Trenton. The meeting opened with a discussion by Dr. A.S. Fell, a health officer of Trenton, on the subject of infant mortality in Trenton. The Society reporter noted that "Dr. Fell confined his remarks to that part of the subject which dealt with the investigations of the Health Department, showing statistics not flattering to the medical profession."[2] Dr. Child was the next speaker at this meeting, demonstrating "with charts and figures, the sections of the city [Trenton] in which the greatest mortality existed. Dr. Child suggested three methods by which the mortality rate may be lowered: a larger Health Department; prenatal care; and broader supervision."[2] The reporter noted that these suggestions were "discussed in detail, with particular emphasis placed upon the importance of both prenatal and postnatal care."[2] After lengthy discussion between the physician-members and the Department of Health officials, the County Society agreed to organize a committee to be appointed by the president, composed of obstetricians, pediatricians, and general practitioners, to confer with the Department of Health on this important subject.[2]

Under her leadership, the rate of mortality among babies was 115 per thousand in 1919 and at the end of 1921, it was down to 70 per thousand. It was Dr. Child's desire "to establish health centers in Trenton where a 24-hour service to the mothers and babies can be given instead of 8-hour service in vogue at present."[4]

Dr. Child was active in other areas: she was a member of the Business and Professional Women's Club of Trenton and of the College Club. Her favorite recreation was motoring and her only hobby was the prevention of disease: "She started out to cure sickness and realized what an awful waste it was, and decided that she would enlist to prevent it."[4] Dr. Child was one of the early advocates for preventive medicine, and she believed that prevention of sickness was "the greatest work the city [Trenton] can do for itself. There is nothing finer for a community than a clean bill of health."[4] Dr. Child devoted herself to the plan of a health center that never closed, for residents to seek medical attention whenever necessary for "permanent health results, prevention of disease, and in fact a real community health service."[4]

RETIREMENT

Dr. Child resigned from her Trenton public health position and the active practice of medicine in 1935, and relocated

to Margate City. Dr. Child lived in southern New Jersey from May to October, and from November to April, she resided in Deerfield Beach, Florida.[5,6] She died at age 71, on March 30, 1957, at North Broward General Hospital, Fort Lauderdale, of carcinoma of the breast with metastases.

Women did not join the Mercer County Medical Society in droves after Dr. Child. By 1930, there were only four other women members: Dr. Hannah Seitzick-Robbins; Dr. Ethel Powis; Dr. Lillian Malone; and Dr. Ellen Potter. The slow pace at which women were elected to membership in this state Society was indicative of the times and the atmosphere. Mercer County medicine was dominated by men, and the reins were tightly held. The men were in control of the hospitals and the private practices. Minutes from the meetings show that few women attended a formal gathering—even when they were inducted. ■

Ms. Hutner is executive editor, *NEW JERSEY MEDICINE.*

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(2) Postgraduate Medical Education Study Committee
(Representation requested by Academy—November 15, 1964)

Palma E. Formica, MD .. Old Bridge
David E. Swee, MD
..... New Brunswick

AIDS Education and Training Center for Health Care Practitioners (RAETC), New Jersey Regional
(Representation requested by UMDNJ—July 6, 1989)

Dominic A. Mauriello, MD
..... Jersey City

AMA-Education Research Foundation
(Liaison requested by AMA—October 7, 1951)

David J. Greifinger, MD ... Belleville

Appointments, Committee on
(Established by Board of Trustees—November 20, 1988)

William E. Ryan, MD,
Chairman ..... Pennington
Joseph A. Riggs, MD
..... Haddon Heights
Joseph N. Micale, MD
..... North Bergen

Archivist Historian
(Appointment requested by the Medical History Society of New Jersey—April 1982)

Morris H. Saffron, MD
..... New York, NY

Audit Review Committee
(Appointed annually to review previous year's audit)

Joel S. Cherashore, MD,
Chairman ..... Nutley
Stevan Adler, MD ... Mountain Lakes
Fred M. Palace, MD ..... Morristown
Gerald H. Rozan, MD,
Consultant ..... Wayne
Matis A. Fermaglich, MD,
Consultant ..... Teaneck
Angelo S. Agro, MD,
Consultant ..... Haddonfield
Michael M. Heeg, MD,
Consultant ..... Trenton

Blindness—New Jersey, National Society To Prevent
(Requested by the National Society To Prevent Blindness—New Jersey—March 19, 1978)

Alfonse A. Cinotti, MD .. Jersey City

Blood Bank Association, New Jersey
(Liaison requested by New Jersey Blood Bank Association—April 25, 1969)

Frank Campo, MD ..... Trenton

Blood Banking Task Force for New Jersey
(UMDNJ—October 1981)

Frank Campo, MD ..... Trenton

Cancer Plan, Task Force To Facilitate the Development of a Statewide
(Representation requested by New Jersey State Department of Health, Division of Epidemiology and Disease Control—September 11, 1990)

Paul E. Wallner, DO ..... Camden

Clinical Laboratory Licensing Review Panel
(Representation requested by New Jersey State Department of Health, Clinical Laboratory Improvement Service—August 14, 1989)

Bernard Robins, MD ..... Union
William E. Ryan, MD .... Pennington

Dental Health, State Task Force for Better
(Representation requested by New Jersey State Department of Health—January 30, 1985)

Glenn P. Lambert, MD .. Flemington

Diabetes Coordinating Council
(Representation requested by New Jersey State Department of Health—November 10, 1980)

Arthur Krosnick, MD ..... Princeton

Drug and Alcohol Problems, Statewide Committee To Assist Local School Districts with
(Representation requested by Department of Education, Regional Curriculum Services Unit-South—June 5, 1984)

Edward Reading, MDiv
..... Lawrenceville

Drug Utilization Review Council, New Jersey
(Representation requested by New Jersey State Department of Health—December 19, 1984)

Harry M. Woske, MD .... Flemington

Education, State Department of
(Liaison requested by Assistant Commissioner of Education—September 21, 1958)

Glenn P. Lambert, MD .. Flemington

Executive Committee
(Provided in the Bylaws, Chapter III (c))

Joseph A. Riggs, MD,
President ..... Haddon Heights
William E. Ryan, MD,
President-Elect ..... Pennington
Joseph N. Micale, MD,
First Vice-President . North Bergen
Fred M. Palace, MD,
Second Vice-President .. Morristown
Douglas M. Costabile, MD,
Immediate Past-President ..... Murray Hill
Bernard Robins, MD,
Secretary ..... Union
Gerald H. Rozan, MD,
Treasurer ..... Wayne

Graduate Medical Education, Advisory Council on
(Representation requested by UMDNJ—1979)

Stephen F. Wang, MD .. Morristown

Health Care Administration Board
(Representation requested—July 1983)

Neil E. Weisfeld ..... Lawrenceville

Health Maintenance Organization Projects, Advisory Committee To Participate in the Review of
(Recommended to Executive Director, Statewide Health Coordinating Council, New Jersey State Department of Health—1974)

Henry J. Mineur, MD ..... Westfield

Hospital Association, New Jersey
(Liaison established at request of New Jersey Hospital Association—December 17, 1967)

Fred M. Palace, MD ..... Morristown

Hospital Medical Staff Section, Governing Council
(Hospital Medical Staff Section established by 1984 House of Delegates)

George T. Hare, MD,
Chairman ..... Haddon Heights
Angelo S. Agro, MD,
Vice-Chairman ..... Haddonfield
Carlo Porcaro, MD,
Secretary ..... Newark
Francis J. Lumia, MD,
Delegate ..... Allentown
Robert L. Wegryn, MD,
Alternate Delegate ..... Elizabeth
Harold R. Reeve, MD,
Member-at-Large ..... Mount Holly
J. Jerome Cohen, MD,
Member-at-Large ..... Lakewood
Harold S. Yood, MD,
Immediate Past-Chairman ..... Plainfield
Joseph C. Lucci ..... Lawrenceville

JEMPAC, Conference Committee with
(Established at request of JEMPAC—June 25, 1967)

Bartholomew R. D'Ascoli, MD
..... Sparta
Richard H. Sharrett, MD N. Plainfield
Fred M. Palace, MD ..... Morristown

Legislation
(1) Federal Keymen (Mechanism established by MSNJ—April 4, 1954—to serve as official intermediaries between MSNJ and the federal legislators): 14 Congressional District Keymen and 2 Senatorial Keymen.

(2) State Keymen (Mechanism established by MSNJ—July 13, 1952): Keymen in 40 Legislative Districts/21 Component Societies.

Medical Assistance Advisory Council
(Established at the request of the New Jersey State Department of Human Services—1980)

James Q. Atkinson, MD
..... Vincentown
Thomas S. Bellavia, MD
..... Hasbrouck Heights

Medical Assistants, New Jersey Society of
(Liaison requested by Society—September 15, 1963)

Giovanni Lima, MD ..... Kearny
Joseph C. Lucci ..... Lawrenceville

Medical Liaison Committees
(High-level conference groups for discussion and consideration of items of mutual interest)

Joseph A. Riggs, MD,
President ..... Haddon Heights
William E. Ryan, MD,
President-Elect ..... Pennington
Joseph N. Micale, MD,
First Vice-President . North Bergen
Fred M. Palace, MD,
Second Vice-President .. Morristown
Douglas M. Costabile, MD,
Immediate Past-President ..... Murray Hill
Bernard Robins, MD,
Secretary ..... Union
Gerald H. Rozan, MD,
Treasurer ..... Wayne
Vincent A. Maressa, *Executive Director, MSNJ* ..... Lawrenceville

(1) **Medical-Dental**
(Liaison requested by Dental Society—June 10, 1951)
(2) **Medical-Hospital**
(Liaison established by MSNJ—October 25, 1953)
(3) **Medical-Legal**
(Liaison established by MSNJ—October 25, 1953)
(4) **Medical-Nursing**
(Liaison established by MSNJ—April 4, 1954)
(5) **Medical-Osteopathic**
(Liaison requested by Osteopathic Association—September 17, 1961)
(6) **Medical-Pharmaceutical**
(Liaison established by MSNJ—July 26, 1953)

Medicare Physicians Advisory Council
(Representation requested by Pennsylvania Blue Shield—July 15, 1990)

Louis L. Keeler, MD
..... Haddon Heights
Richard H. Sharrett, MD N. Plainfield
R. Gregory Sachs, MD ..... Summit
Ian Samson, MD ..... Lakewood

Mental Retardation, Governor's Council on the Prevention of
(Appointed by the Governor—June 22, 1984)

Stanley S. Bergen, Jr, MD .. Newark

Nursing Advisory Committee, New Jersey State Department of Health
(Representation requested by New Jersey State Department of Health—1988)

Ralph A. Skowron, MD . Cherry Hill

Osteopathic Physicians and Surgeons, New Jersey Association of
(Invitation to attend Board meetings extended to MSNJ President—July 24, 1986)

Joseph A. Riggs, MD,
President ..... Haddon Heights

Pharmaceutical Assistance to the Aged and Disabled Advisory Council
(Appointed by Commissioner of the New Jersey State Department of Human Services—physician representation requested by Division of Medical Assistance and Health Services—December 19, 1980)

Frank J. Malta, MD ..... Toms River

Pharmacopeial Convention, The United States
(Delegate authorized to be seated—August 1988)

For information on 1991-1992 MSNJ Liaison Representatives, call 609/896-1766
Medical Society of New Jersey
Two Princess Road
Lawrenceville, NJ 08648

Joseph N. Micale, MD
..... North Bergen

Radiation Protection, Advisory Committee on Nuclear Medicine to New Jersey Commission on
(Consultants in nuclear medicine appointed by Commission—November 20, 1966)

Henry J. Powsner, MD ..... Princeton

Radiation Protection, Ad Hoc Committee on Educational Project of the Commission on
(Appointed by Board of Trustees—November 20, 1988)

Carl Restivo, Jr, MD ..... Jersey City

Resolutions, Committee on Annual Meeting
(Established by Board of Trustees, July 18, 1971, to review emergency resolutions in advance of the Annual Meeting)

Palma E. Formica, MD,
Chairman ..... Old Bridge
Paul J. Hirsch, MD ..... Bridgewater
Douglas M. Costabile, MD
..... Murray Hill

Safety Council, New Jersey State
(Provided in Council Bylaws—1962)

Joseph A. Riggs, MD
..... Haddon Heights

Society for the Assistance of New Jersey Physicians and their Families, The
(Liaison requested by Society—May 17, 1959)

David I. Canavan, MD
..... Lawrenceville

State Board of Medical Examiners
(Member of MSNJ executive staff to attend monthly meetings—per Board of Trustees, August 8, 1979, and per presidential appointment, September 15, 1991)

Fred M. Palace, MD ..... Morristown
Neil E. Weisfeld ..... Lawrenceville

Statewide Health Coordinating Council (SHCC) and/or its Review Committee
(Liaison established January 15, 1978)

Neil E. Weisfeld ..... Lawrenceville

UMDNJ, Foundation of the
(MSNJ representative appointed yearly by the Board of Trustees to serve as a trustee, pursuant to the Bylaws of the Foundation—1979)

Arthur Bernstein, MD ..... S. Orange

Waste Management, Advisory Council on Solid
(Appointed by Governor—April 1989)

Stanley R. Lane, MD .... Moorestown

STATEMENT OF OWNERSHIP, MANAGEMENT, AND CIRCULATION

(Required by 39 U.S.C. 3685)

1A. Title of Publication: *NEW JERSEY MEDICINE, The Journal of the Medical Society of NJ.*

1B. Publication No.: 0885842X.

2. Date of Filing: September 20, 1991.

3. Frequency of Issue: Monthly.

3A. No. of Issues Published Annually: 12.

3B. Annual Subscription Price: $35.

4. Complete Mailing Address of Known Office of Publication: 2 Princess Road, Lawrenceville, Mercer County, NJ 08648.

5. Complete Mailing Address of the Headquarters of General Business Office of the Publisher: 2 Princess Road, Lawrenceville, Mercer County, NJ 08648.

6. Names and addresses of publisher, editor, and managing editor: Publisher, Medical Society of New Jersey, 2 Princess Road, Lawrenceville, NJ 08648. Editor: Howard D. Slobodien, MD, 2 Princess Road, Lawrenceville, NJ 08648. Managing Editor: Geraldine R. Hutner, 2 Princess Road, Lawrenceville, NJ 08648.

7. Owner (If owned by a corporation, its name and address must be stated and also immediately thereunder the names and addresses of stockholders owning or holding 1 percent or more of total amount of stock. If not owned by a corporation, the names and addresses of the individual owners must be given. If owned by a partnership or other unincorporated firm, its name and address, as well as that of each individual must be given. If the publication is published by a nonprofit organization, its name and address must be stated.): Medical Society of New Jersey, 2 Princess Road, Lawrenceville, NJ 08648.

8. Known bondholders, mortgagees, and other security holders owning or holding 1 percent or more of total amount of bonds, mortgages, or other securities: None (a nonprofit corporation of New Jersey).

9. For completion by nonprofit organizations authorized to mail at special rates (DMM Section 423.12 only). The purpose, function, and nonprofit status of this organization and the exempt status for federal income tax purposes have not changed during preceding 12 months.

10. Extent and nature of circulation:

Extent and nature of circulation	Average no. copies each issue during preceding 12 months	Actual no. copies of single issue published nearest to filing date
A. Total no. copies (net press run)	10,300	10,159
B. Paid and/or requested circulation		
1. Sales through dealers and carriers, street vendors, and counter sales	—	—
2. Mail subscription (paid and/or requested)	9,491	9,350
C. Total paid and/or requested circulation (sum of 10B1 and 10B2)	9,491	9,350
D. Free distribution by mail, carrier, or other means: samples, complimentary, and other free copies	589	589
E. Total distribution (sum of C and D)	10,080	9,939
F. Copies not distributed		
1. Office use, left-over, unaccounted, spoiled after printing	220	220
2. Return from news agents	—	—
G. Total (sum of E, F1 and 2—should equal net press run shown in A)	10,300	10,159

11. I certify that the statements made by me above are correct and complete.

(signed) Geraldine R. Hutner
Managing Editor

NEW JERSEY MEDICINE

RATE CARD 1992

Publisher: Medical Society of New Jersey
Advertising Office: 609-393-7196

Advertising Representative: (non-pharmaceutical)
Cookson Media Services, Inc.
370 Morris Avenue
Trenton, NJ 08611
609-393-7196

Advertising Representative: (pharmaceutical)
United Media Associates
16 Bruce Park Avenue
Greenwich, CT 06830
203-661-9702

General Information

1. Issuance:
a. Frequency: Monthly
b. Issue date: 10th of month
c. Mailing date: 10th of month

2. Established:
1904

3. Organization Affiliation:
Official publication of the Medical Society of New Jersey

4. Circulation Data:
a. Controlled circulation to all members of the Medical Society of New Jersey. Member's subscription is included in Society dues. Rates for nonmembers $35, outside USA add $15 for postage. Single copies $3 except special issues.
b. Annual percentage of subscription renewals: 100% of members.
c. Number of issues sent after subscription expiration: None.

5. Special Issue:
Index (December)

6. Editorial Content:
Newswatch, Membership Newsletter, Professional Liability Commentary, Editorials, Scientific Articles, Special Articles, Case Reports, Commentary, Contemporary Clinical Nutrition, Impaired Physicians Program, Medical News and Meeting Notices, Trustees' Minutes, State Legislation, Annual Meeting, Medical Insurance, Continuing Medical Education, JEMPAC Reportorial, Review Articles, State-of-the-Art Articles, Doctors' Notebook, Letters to *NEW JERSEY MEDICINE,* Personal Items, Obituaries, Book Reviews, Medical Histories.

7. Requirement for Acceptance of New Professional Products for Advertising:
All advertising subject to Publication Committee approval.

8. Requirement for Advertising Clearance:
All advertising subject to Publication Committee approval.

9. Advertising Acceptance of Nonprofessional Products or Services:
All advertising subject to Publication Committee approval.

10. Policy on Placement of Advertising:
Advertising is interspersed throughout the publication. All R.O.B. ads are rotated each month. Advertising and editorial material is not placed on the same page.

11. Advertiser's Index:
None.

12. Services to Advertisers:
Availability of editorial reprints: Please direct such requests to the Executive Editor.

13. Staff:
Editor-In-Chief: Howard D. Slobodien, MD; Executive Editor: Geraldine R. Hutner; Executive Director: Vincent A. Maressa.

14. Circulation:
All members of the Medical Society of New Jersey.

15. Guaranteed Circulation:
All members of the Medical Society of New Jersey.

16. Circulation Verification:
Publisher's statement, postal receipt verification.

17. Rates Per Thousand:
Based on the 12-times rate of $575 and circulation of 10,500: $54.76.

NEW JERSEY MEDICINE

Rate Card effective January 1992

18. Coverage and Market:

a. Coverage: All members of the Medical Society of New Jersey, plus trade circulation.

b. Physician Count:

Internal Medicine	1,947
Family Medicine	898
Surgery	885
Obstetrics/Gynecology	745
Pediatrics	601
Orthopedics	515
Radiology	447
Anesthesiology	412
Ophthalmology	388
Cardiology	370
Psychiatry	360
Pathology	345
Urology	240
Neurology	236
Otolaryngology	195
Emergency Medicine	88
Oncology	73
Allergy	72
Faculty, Residents, Students, Misc.	644
Total	9,461

c. Trade Circulation:

Non-member physicians	
Medical libraries	
Medical schools	
Drug manufacturers	
Medical book publishers	
Medical abstract services	
Advertisers	
Advertising agencies	
Subscriptions	
Total approximately	1,150

19. Membership Circulation by Counties of the State of New Jersey:

Atlantic	259
Bergen	1,244
Burlington	319
Camden	649
Cape May	47
Cumberland	101
Essex	1,420
Gloucester	113
Hudson	365
Hunterdon	99
Mercer	548
Middlesex	707
Monmouth	619
Morris	609
Ocean	371
Passaic	662
Salem	45
Somerset	204
Sussex	81
Union	940
Warren	59
Total	9,461

Guaranteed Circulation: 10,500

NEW JERSEY MEDICINE

Rate Card effective January 1992

Rates

20. Issuance:

a. Frequency: Monthly
b. Issue Date: 10th of month
c. Mailing Date: 10th of month

21. Closing Dates for Space:

a. Reservations: 1st of month preceding month of issue
b. Cancellations: 6th of month preceding month of issue

22. Agency Commission:

15%

23. Black and White Rates Per Insertion:

	1X	3X	6X	12X
One page	$575	$565	$555	$545
1/2 page	300	295	290	285
1/4 page	160	155	150	145
1/8 page	85	80	80	75

Classified: Paragraph classified ads available to member physicians only

24. Earned Rates:

Rates based on number of insertions used within one year, regardless of size. Space purchased by a parent company and subsidiaries is combined for accounting of earned rates.

25. Color Rates:

a. Standard color $250 plus earned black and white rate.

b. List of standard colors: AAAA standard red, green, blue, yellow, orange.

c. Matched Colors: $300 plus earned black and white rate.

d. 4-color rate: $600 plus earned black and white rate.

26. Bleed:

No bleed charge.

27. Inserts:

60 pound coated only.

2 page furnished inserts—2x b/w rate; 4 page furnished inserts—4x b/w rate.

28. Specific Position Rates:

Specific position rates quoted on request and subject to availability.

29. "Dual Responsibility":

Billing directed to the advertising agency at the net rate is approved on condition that the advertiser will accept "dual responsibility" for payment if the agency does not remit within 90 days. Advertising accounts in arrears 60 days will be billed in duplicate to both the agency and the advertiser.

NEW JERSEY MEDICINE

Rate Card effective January 1992

Mechanical Requirements

New Jersey Medicine is printed by offset.
Trim size: 8 x 11

30. Non-Bleed Sizes:

Page Unit	Dimensions (width x depth)
1 full page	7 x 10
½ horizontal	7 x 4⅞
½ vertical	3⅜ x 10
¼ vertical	3⅜ x 4⅞
⅛ vertical	3⅜ x 2⅜

31. Bleed Sizes:

Page Unit	Dimensions (width x depth)
1 full page	8⅛ x 11¼
½ horizontal	8⅛ x 5⅝
½ vertical	4 1/16 x 11¼

32. Insert Requirements:
Untrimmed size—8¼ x 11¼
Quantity—12,000

33. Paper Stock:
Covers: 80-pound. Inside pages: 55 or 50 pound.

34. Type of Binding:
Perfect bound.

35. Halftone Screen:
Up to 133 screen.

36. Reproduction Requirements:
Black and white positives and 2-color advertisements: negatives, camera-ready mechanicals, and art work acceptable.

4-color: film negatives or positive separations and press proof.

Offset film negatives or positives on .002 or .004 stable base materials must have register marks, center marks and trim marks clearly indicated. Each negative must be marked for color and be right reading emulsion side down.

37. Closing Dates for Materials:

a. Negatives or positives, camera ready mechanicals, and art work: 10th of the month preceding month of issue.

b. Publication set copy: 5th of month preceding month of issue.

c. Contact advertising office (609-393-7196) if extensions necessary. All extensions subject to approval.

38. Disposition of Reproduction Material:
Material is held for one year and then destroyed.

39. Miscellaneous:

a. Contract requirements: All contracts subject to publisher's approval.

b. Statement of guarantee of uniform rates and discounts to all advertisers using same amount and kind of space: No exceptions to published rates.

c. Concessions: None.

d. Rates subject to change with 90 days notice. Contracts accepted with understanding that rates will be guaranteed for three months beyond last issue closed. In the event of rate increase, contracts may be terminated without penalty of short rate.

40. Addresses:

Non-Pharmaceutical Sales, general information:
Cookson Media Services, Inc.
370 Morris Avenue
Trenton, NJ 08611
609-393-7196

Pharmaceutical Sales:
United Media Associates, Inc.
16 Bruce Park Avenue
Greenwich, CT 06830
203-661-9702

Contracts, insertion orders, reproduction material:
Advertising Office
NEW JERSEY MEDICINE
370 Morris Avenue
Trenton, NJ 08611
609-393-7196

Inserts: (12,000)
NEW JERSEY MEDICINE
MACK Printing Company
1991 Northampton Street
Easton, PA 18042-3189

HOUSING APPLICATION

226th ANNUAL MEETING
THE MEDICAL SOCIETY OF NEW JERSEY
MAY 3-6, 1992

TRUMP TAJ MAHAL CASINO/RESORT
1000 BOARDWALK AT VIRGINIA AVENUE, ATLANTIC CITY, NJ 08401
RESERVATION DEPARTMENT 1/800/825-8786

(Please Print)

Name _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Business Phone _____

Sharing With _____

Date of Arrival _____ Time _____

Date of Departure _____ Time _____

A one-night deposit (equivalent to room rate) is required with all reservation requests. Please send check or money order payable to the **TRUMP TAJ MAHAL CASINO/RESORT** or complete the following:

Card # _____ Type _____ Exp. Date _____

SCHEDULE OF RATES SUBJECT TO 13% TAX
☐ SINGLE **$115** ☐ DOUBLE **$115** *(Reservations must be received prior to April 2, 1992)*
Extra Person **$25**
☐ One-Bedroom Suite **$275 per day**
☐ One-Bedroom Hospitality Suite **$300 per day**

Check-out time is 12 Noon. Rooms may not be available for check-in until after 3 p.m. Check-in time on Sundays is 5 p.m. FORTY-EIGHT (48) HOURS NOTICE OF CANCELLATION is required for a full refund.

PARKING: FREE PARKING TO REGISTERED GUESTS. One car per room.

☐ Check if Official Delegate _____ County _____

****

MAIL THIS APPLICATION TO:

Reservations
Trump Taj Mahal Casino/Resort
1000 Boardwalk at Virginia Avenue
Atlantic City, New Jersey 08401
Tel: 1/800/**825/8766**

DOCTORS' NOTEBOOK

TRUSTEES' MINUTES

A regular meeting of the Board of Trustees was held on September 15, 1991, at the MSNJ executive offices in Lawrenceville. Detailed minutes are on file with the secretary of your county society. A summary of significant actions follows:

Open Forum. Discussed the following topics in the first open forum: the success of the grassroots campaign to have physicians contact legislators concerning Medicare physician payment reform (RBRVS); the AIDS conference on October 30, 1991, sponsored by MSNJ, the New Jersey Hospital Association, the Academy of Medicine of New Jersey, and the Educational Trust of New Jersey; and disability insurance for physicians.

President's Report.

1. Acknowledgements. Welcomed Dr. Cristeta Laurente, president of the Phillipine American Medical Society of New Jersey; Dr. Sanford M. Lewis, president of the State Board of Medical Examiners; and Drs. Franzoni, Keeler, and Weierman who have recovered from recent major surgery.

2. Advance Directives for Health Care/Living Wills. Was advised that the form for the advance directives for health care was designed by the New Jersey Bioethics Commission and conforms to state law. Also, noted that MSNJ's Committee on Seniors, in conjunction with county medical society senior citizens committees, are planning educational sessions on advance directives.

Report of Executive Director.

1. MSNJ Financial Statements. Reviewed and approved MSNJ's financial statements for the periods ending May 31, June 30, and July 31, 1991.

2. HCFA Clinical Laboratory Survey. Was informed that Pennsylvania Blue Shield (PBS) sent survey forms to providers of clinical laboratory services in the states in which PBS is the Medicare carrier; the form must be completed to the best of the physician's ability and returned by October 1, 1991, and failure to do so could result in a civil monetary penalty of up to $10,000 per day.

3. NJ Health Lawyers Association. Authorized cosponsorship of a program on universal health care, to be held on November 6, 1991.

4. Medical Waste Registration. Noted that the program to register generators of medical waste in New Jersey is completed.

UMDNJ Report. Noted the following items from Dr. Stanley S. Bergen, Jr, president of UMDNJ: his election to the Board of Trustees of the American Hospital Association; appreciation for the special session of the House of Delegates to reconsider its position on physician assistants; thanks to Dr. Riggs for his opening day remarks; the decision not to inform patients of a surgeon on staff who tested positive for the AIDS virus; and the 1991 AIDS walkathon.

New Jersey Hospital Association Report. Noted the following items from Fred M. Palace, MD, MSNJ's liaison to the New Jersey Hospital Association: Governor Florio's request for an investigation of hospital billing practices; and safe harbor regulations that control the relationships between hospitals and their physicians in setting up various joint ventures.

Judicial Council. Reviewed the revised opinion of the Council concerning Opinion #14, Interest Rate Charges (italics denotes changes):

A physician who has experienced problems with delinquent accounts may properly choose to add interest or other reasonable billing charges to delinquent accounts. *The patient must be notified in advance* of the interest or service charges by means of posting a notice in the waiting room, the distribution of leaflets in the office, and appropriate notations on billing statements.

Although the Council has reservations regarding this entire mechanism, a charge of 1.5 percent per month is legally permissible. Physicians are encouraged to make exceptions in hardship cases.

The Council does not believe it is appropriate to add attorneys' fees, court costs, or collection costs to the amount owed. *If, however, costs and fees are added by court determination, it is appropriate to collect them.*

Ad Hoc Committee on Membership. Referred the following recommendations concerning members in their first year of practice to the Committee on Finance and Budget for consideration and report back to the Board:

That the first year of FULL membership be billed at the rate of 50 percent of regular dues.

That the second year of FULL membership be billed at the rate of 75 percent of regular dues.

That the AMA Delegation be requested to recommend that a similar policy be adopted for AMA membership.

MSNJ Auxiliary. Noted the following items from Marion H. Geib, president-elect: sponsorship of a media training session, "Medicine and the Media" on

September 25; annual trip to Washington, DC, on April 1 and 2, 1992; and the successful letter writing campaign opposing the 16 percent reduction in the Medicare conversion factor.

Unfinished Business.

1. AMA Intent To Bill and Delegate Moratorium Programs. Noted that an all-day session for county society executives is planned for October 17, 1991, to discuss the criteria for the 1993 dues bill and membership marketing plans.

2. Eye Health Care Week. Called attention to the Eye Health Screening Program that offers testing for glaucoma and cataracts, under the auspices of MSNJ's Committee on Conservation of Vision, the New Jersey Academy of Ophthalmology and Otolaryngology, and seven other health care organizations.

New Business.

1. AMA Council on Legislation. Unanimously endorsed Edward A. Schauer, MD, as a candidate for the AMA Council on Legislation.

2. AMA Awards. Authorized the president to select individuals to serve on a new MSNJ Committee on Awards.

3. PRO Legal Representation Program. Noted that all MSNJ's officially endorsed programs are reviewed each year by the Committee on Membership Services.

4. MSNJ Liaison to the State Board of Medical Examiners (SBME). Gave the president the discretion of appointing a liaison representative to SBME.

5. Medical Inter-Insurance Exchange of New Jersey (MIIENJ). Noted that MIIENJ has been reorganized to reflect its maturity and the changing liability market; MIIENJ is sound financially, has begun returning physician surplus contributions, and continues to provide high-quality coverage at the most efficient rates possible. □

UMDNJ NOTES

Partnerships with Pharmaceutical Firms. Charles C. Carella, the new chairman of the Board of Trustees of the University of Medicine and Dentistry of New Jersey (UMDNJ), has called for a partnership between UMDNJ and the state's pharmaceutical industry. The goal, he said, is to ensure that UMDNJ and New Jersey capture a substantial portion of the $2 billion spent annually nationwide by the industry for research and development.

Neurology Department Gains Federal Designation. The Department of Neurology at UMDNJ-Robert Wood Johnson Medical School has been named a national Center of Excellence for Parkinson's Disease Research. The designation was made by the American Parkinson's Disease Association (APDA). UMDNJ-Robert Wood Johnson Medical School is the second medical school in the nation to receive the APDA designation. The designation carries with it five-year, $500,000 grant.

The UMDNJ Board of Trustees has named the center, The Richard E. Heikkila Center of Excellence in honor of the late Dr. Heikkila, professor of neurology and pharmacology at the medical school and an internationally rec-

1992 MSNJ Annual Meeting Proposed Daily Schedule

Saturday, May 2, 1992

3:30 p.m. Board of Trustees' Meeting

Sunday, May 3, 1992

8:00 a.m. Registration Opens
9:30 a.m. Message Center Opens
10:00 a.m. Educational Program
11:30 a.m. Exhibits Open
2:00 p.m. House of Delegates
3:30 p.m. Reference Committee Meetings

Monday, May 4, 1992

8:00 a.m. Registration Opens
8:00 a.m. Message Center Opens
8:30 a.m. Exhibits Open
9:00 a.m. House of Delegates (Election)
12:00 noon Golden Merit Award Ceremony and Reception
2:30 p.m. Reference Committee Meetings
5:00 p.m. JEMPAC Political Forum
5:45 p.m. JEMPAC Wine and Cheese Reception
6:30 p.m. Camden County Medical Society Reception

Tuesday, May 5, 1992

8:00 a.m. Registration Opens
8:00 a.m. Message Center Opens
8:30 a.m. Exhibits Open
9:00 a.m. House of Delegates
1:30 p.m. House of Delegates
2:00 p.m. Exhibits Close
7:00 p.m. Inaugural Reception and Dinner

Wednesday, May 6, 1992

8:00 a.m. Registration Opens
8:00 a.m. Message Center Opens
8:30 a.m. General Session (Educational Program)
1:00 p.m. Board of Trustees' Meeting

ognized researcher in Parkinson's disease.

NIH Grant Review Committee. Dr. Masayori Inouye has been appointed to serve on a review committee of the Division of Research Grants of the National Institutes of Health (NIH). Dr. Inouye is chairman of the Department of Biochemistry at UMDNJ-Robert Wood Johnson Medical School. He will serve as a member of the Microbial, Physiology, and Genetics 2 Study Section of NIH's Division of Research Grants. His letter of appointment noted that he was invited to serve on the committee because of demonstrated competence and achievement in the field of biochemistry as evidenced by the quality of his research accomplishments, publications in scientific journals, and other significant honors.

Smith Library Displays AIDS Poster Exhibit. An exhibit of posters and photographs of musicians who participated in "Bands to Beat AIDS" opened September 25, 1991, at UMDNJ's Newark campus. The exhibit features posters and candid photographs of several of the artists who participated in the statewide campaign to teach teens about AIDS. The exhibit is on display through January 30, 1992, at UMDNJ-George F. Smith Library of the Health Sciences, Newark. □ Stanley S. Bergen, Jr, MD

MSNJ AUXILIARY

The Medical Society of New Jersey Auxiliary (MSNJA) is planning a trip on April 1-2, 1992, to Washington, DC, to visit legislators. Working on the committee for the joint MSNJ and Auxiliary venture are Paul J. Hirsch, MD, chairman; Walter J. Kahn, MD; Anthony P. Caggiano, Jr, MD; Charles M. Moss, MD; Irving P. Ratner, MD; John P. Capelli, MD; Jane Lorber; and Angie Campo.

The itinerary includes a visit to the Washington Cathedral, dinner with a legislative briefing, and an overnight stay at the Georgetown University Conference Center and Guest House. On Thursday, April 2, physicians and Auxiliary members will visit New Jersey congressmen and senators at their Capitol Hill offices and depart Washington in the early afternoon. The trip, which costs $150, includes room, one luncheon, one dinner, breakfast, and bus transportation from three locations in New Jersey. Reservations can be made by sending a check for $75 to MSNJA, at Society headquarters in Lawrenceville.

Also planned for spring is the Auxiliary's annual teen health forum. Entitled "Choices, Not Chances," the program will be held in Lawrenceville on Tuesday, March 24, 1992. High school faculties and students from across the state are expected to attend. Topics to be addressed at the workshop are eating disorders, skin care and the sun, sports medicine, defensive driving, teen pregnancy and sexually transmitted diseases, and substance abuse. Members of the Medical Society and Auxiliary are cordially invited. □ Marion H. Geib

AMNJ REPORT

The Fifth Annual Governor's Jersey Pride Awards Program was held on September 19, 1991, with the presentation of 14 awards to distinguished New Jerseyans. The recipient of the 1991 Clara Barton Medical Service Award was Dr. Donald B. Louria, chairman of the Department of Preventive Medicine and Community Health at UMDNJ-New Jersey Medical School. The Academy and the American Red Cross are responsible for recommending nominees for this Award.

The Committee on Awards and Special Events of AMNJ still is soliciting recommendations for candidates for the Edward J. Ill and the Citizen Awards. The Committee will make its final recommendations for these awards to the Board of Trustees on November 21, 1991, and the announcement will be made immediately afterward. The awards will be given at the Annual Awards Dinner on May 27, 1992, at the Chanticler in Short Hills.

The Academy recently has been funded by the New Jersey State Department of Health (NJDOH) to develop three new Roving Symposia Series. "Diabetes-Related Cardiovascular Disease," chaired by Norman Ertel, MD, will supplement the existing four complications of diabetes. The NJDOH Gerontology Program has funded a series: "Medical Problems in the Elderly." Morris Green, MD, PhD, will chair the program. George McSherry, MD, is developing a roving symposia series to supplement the recently completed protocol, "HIV in Infants and Children." These one-hour lectures are available at no charge to New Jersey hospitals. All three series will be available in Janaury 1992. To request any of the aforementioned programs for your institution as well as existing funded roving symposia, contact Mae Slabicki, education program coordinator at 609/896-1717.

The Academy participates in a consortium of medical schools and societies known as PICME (Physician Initiated CME). The purpose of this CME delivery system is to encourage physicians to participate in self-directed learning projects that qualify for AMA/PRA Category 1 credit. The

guidelines have been established and must incorporate the important elements of substantive adult learning, namely:

1. Learner initiated in response to problems, requests, or curiosity.
2. Have identifiable and measurable objectives that lend themselves to quantifiable evaluation.
3. Require active involvement of the learner.
4. Result in tangible products that can be reviewed and evaluated by others.

To participate in a PICME project, contact: Ronnie Davidson, EdD, 609/896-1717. □
Gerald Shapiro, MD, President

PLACEMENT FILE

The following physicians have written to the executive offices of MSNJ seeking information on opportunities for practice in New Jersey. If you are interested in any further information concerning these physicians, we suggest you make inquiries directly to them.

Cardiology

George D. Birmingham, MD, 3531 Salerno Ct., Apt. 5, Middleton, WI 53562. Mount Sinai 1984. Board eligible. Board certified (IM). Group or partnership. Available.

Alan E. Kravitz, MD, 26900 Cedar Rd., #304, Beachwood, OH 44122. Jefferson 1969. Also, internal medicine. Board certified. Also, board certified (IM). Group or partnership. Available.

Internal Medicine

Thomas P. Hooker, DO, 2804 Sitios St., Tampa, FL 33629. Philadelphia College of Osteopathic Medicine 1984. Board certified; also, PUL. Solo or multispecialty group. Available.

Marc Kesselhaut, MD, 1 Rustic Ridge, C16, Little Falls, NJ 07424. St. George's University 1986. Board eligible. Solo or partnership in Mercer, Somerset, Burlington, Hunterdon, or Middlesex counties. Available.

Alan E. Kravitz, MD, 26900 Cedar Rd., #304, Beachwood, OH 44122. Jefferson 1969. Also, cardiology. Board certified. Also, board certified (C). Group or partnership. Available.

Cynthia K. Menack, MD, 3132 Perry Ave., Apt. 2A, Bronx, NY 10467. Mount Sinai 1989. Board eligible. Group practice or medical clinics. Available July 1992.

John Musico, MD, 262 Pine Valley Rd., Dover, DE 19901. St. George 1988. Board eligible. July 1992.

M. Stekelman, MD, P.O. Box 900, Hightstown, NJ 08520. BSAS (Argentina) 1959. Also, gastroenterology. Board eligible. Outpatient or ambulatory facility. Available.

Nephrology

Vinitha Raj, MD, 82-30 26th St., Floral Park, NY 11204. Guntar Medical School (India) 1981. Board eligible. Board certified (IM). Group or partnership.

Pediatrics

Donna Churlin, MD, 55 Montgomery St., Bloomfield, NJ 07003. UMDNJ 1987. Board eligible. Partnership or group in central New Jersey (Essex, Union, or Morris counties). Available.

Sheryl S. Hertel, MD, 6205 Brogan Pl., St. Louis, MO 63128. St. Louis 1986. Also, internal medicine. Board eligible. Board certified (IM). Group. Available.

Radiation Oncology

Carol L. Kornmehl, MD, 133 Wyncrest Rd., Marlboro, NJ 07746. SUNY-Downstate 1984. Board certified. Group, partnership, solo. Available.

Surgery

Victoria Lee, MD, 459 South St., #204, Fitchburg, MA 01420. Howard 1981. Board certified. Group, HMO, partnership. Available.

CANDIDATES FOR MSNJ OFFICES

If you are interested in becoming an officer, trustee, or member of the AMA Delegation, a new opportunity is available for you. The Nominating Committee will meet on Wednesday, February 5, 1992, to consider candidates. We will consider members other than those recommended by county medical societies and nominating delegates for any of these offices.

If you wish to be considered, please contact your county medical society or the Medical Society of New Jersey (609/896-1766) for the necessary forms.

This is a real opportunity for grassroots candidate development and we urge you to use it.

MEETINGS OF THE BOARD OF TRUSTEES of the Medical Society of New Jersey

November 17, 1991
December 15, 1991
January 19, 1992
February 9, 1992
March 15, 1992
April 15, 1992

Meetings of the Board of Trustees are open to all physicians. The meeting on March 15, 1992, is an OPEN FORUM, to allow physicians the opportunity to stand up and be heard. If you would like to attend the OPEN FORUM, please contact Diana Gore, MSNJ Headquarters, 609/896-1766.

DEBORAH HEART AND LUNG CENTER

DEPARTMENT OF PULMONARY MEDICINE

PRESENTS

EIGHTH ANNUAL CLINICAL UPDATE IN PULMONARY MEDICINE

Saturday, December 7, 1991
Caesars Atlantic City
Atlantic City, New Jersey

Designed for Family Practitioners, Internists, Pulmonologists, and Allied Health Care Professionals

8 Hours Category 1 CME Credit
Spouse Program/Optional Activities

PROGRAM

Acute Pulmonary Embolism.....Roger Bone, MD

Radiology of the Pneumoconioses.....William K.C. Morgan, MD

The Clara Falk Franks Lecture - Respiratory Failure and Multi-organ Failure: New Concepts .....Roger Bone, MD

Asbestosis and Asbestos-Related Pleural Disease .....William K.C. Morgan, MD

Hypersensitivity Pneumonitis.....David Murphy, MD

Acute Respiratory Failure in Chronic Obstructive Pulmonary Disease.....Thomas Petty, MD

Community Acquired Pneumonia-1991 .....John Bartlett, MD

Newer Approaches to Asthma Management .....Thomas Petty, MD

Opportunistic and Nosocomial Pulmonary Infections.....John Bartlett, MD

Drug-Induced Lung Disease: A Microcosm of Pulmonary Medicine.....Mervyn Feierstein, MD

For information contact :
Center for Bio-Medical Communication, Inc.
80 West Madison Avenue, Dumont, NJ 07628 (201) 385-8080

Acupuncture & Electro-Therapeutics in Clinical Practice

New York State Boards of Medicine & Dentistry 25-hour accredited seminar & workshop on latest theories & techniques of manual & electro-acupuncture, TENS & simple non-invasive diagnostic methods (including cardio-vascular, neuromuscular, central nervous systems & "Bi-Digital O-Ring Test"), applicable towards 300-hour requirement for certification to practice acupuncture, will be given periodically for licensed clinicians (with or without prior training) on 3-day weekends (Fri-Sun) of Nov. 22-24, and Dec. 13-15, 1991, at Milford Plaza Hotel, 45th St. & 8th Ave., New York City.

These meetings are co-sponsored by the International College of Acupunture & Electro-Therapeutics & its official journal, Acupuncture & Electro-Therapeutics Research, The International Journal (published by Pergamon Press & indexed in 15 major indexing periodicals, including Index Medicus), Heart Disease Research Foundation; NY Pain Center; Electrical Engineering Dept., Manhattan College; Nordic Medical Acupuncture Society (Scandinavia); Schmerz Therapeutische Kolloquium (West Germany); Japan Bi-Digital O-Ring Test Assn.; Accredited toward Acupuncture Certification to practice acupuncture. Eligible for AMA CME Cat. I credit (about 40 credit-hours for the Symposium).

For information on meetings or submission or presentations of papers, contact Symposium Chairman, Prof. Y. Omura, M.D., Sc.D., 800 Riverside Drive (8-I) New York, NY 10032 Tel: (212) 781-6262 (10 am to 10 pm 7 days a week) or (212) 928-0658, Co-chairman, Prof. A.W. Cook, MD (516) 877-1821, or Bro. Michael Losco (212) 920-0162.

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CONTINUING EDUCATION

ANESTHESIOLOGY

January

21 **Anesthesiology Membership Meeting**
All day—Ramada Inn, Clark
(NJ State Society of Anesthesiologists)

29 **Anesthesiology for Laser Surgery**
10:30-11:30 A.M.—Christ Hospital, Jersey City
(AMNJ)

DERMATOLOGY

December

4 **Dermatology Grand Rounds**
11 6-9 P.M.—Rutgers Community
18 Health Plan, New Brunswick
(UMDNJ)

January 1992

8 **Dermatology Grand Rounds**
15 6-9 P.M.—Rutgers Community
22 Health Plan, New Brunswick
29 *(UMDNJ)*

14 **Monthly Meeting**
7 P.M.—Schering Corporation, Kenilworth
(Dermatological Society of New Jersey and AMNJ)

INFECTIOUS DISEASE

December

6 **Inter-Jersey Infectious**
13 **Disease Rounds**
20 Hackensack Medical Center,
27 Newark Beth Israel Medical Center, St. Joseph's Hospital and Medical Center, Overlook Hospital, and University Hospital
(UMDNJ and AMNJ)

9 **Chronic Epstein-Barr Virus**
1-2 P.M.—New Lisbon Developmental Center, New Lisbon
(AMNJ and NJDOH)

12 **Identification and Management of Asymptomatic HIV Infection**
1-2 P.M.—James J. Howard VA Outpatient Clinic, Brick
(AMNJ and NJDOH)

12 **Identification and Management of Asymptomatic HIV Infection**
1:30-2:30 P.M.—Essex County Hospital Center, Cedar Grove
(AMNJ)

18 **Identification and Management of Asymptomatic HIV Infection**
8-9 A.M.—Barnert Hospital, Paterson
(AMNJ and NJDOH)

January

3 **Inter-Jersey Infectious**
10 **Disease Rounds**
17 Hackensack Medical Center,
24 Newark Beth Israel Medical
31 Center, St. Joseph's Hospital; Overlook Hospital, and University Hospital
(UMDNJ and AMNJ)

9 **AIDS Training and Resource Program for Hospital Health Educators**
1:30-2:30 P.M.—Essex County Hospital Center, Cedar Grove
(AMNJ)

22 **AIDS Training and Resource Program for Hospital Health Educators**
12 Noon-1 P.M.—Medical Center of Ocean County, Point Pleasant
(AMNJ)

31 **Diagnosis and Treatment of AIDS**
8:30-9:30 A.M.—Chilton Memorial Hospital, Pompton Plains
(AMNJ and NJDOH)

MEDICINE

December

3 **Hepatatis B and C**
12:15-1:30 P.M.—John Fitch Plaza, Trenton
(AMNJ and NJDOH)

4 **Ophthalmology Meeting**
All day—Ocean Place Hilton, Long Branch
(NJ Academy of Ophthalmology and Otolaryngology)

4 **Endocrinology Monthly Meeting**
6-9 P.M.—Holiday Inn, Newark Airport, Newark
(AMNJ)

4 **Endocrinology Grand Rounds**
11 11:30 A.M.-1 P.M.—VA Medical
18 Center, East Orange
(AMNJ)

4 **Interhospital Endocrine**
11 **Rounds**
18 3:30-5:30 P.M.—Newark Beth Israel Medical Center, University Hospital, VA Medical Center, and United Hospitals Medical Center
(AMNJ)

4 **Prevention of Lower Extremity Amputations**
9-10 A.M.—Warren Hospital, Phillipsburg
(AMNJ and NJDOH)

4 **JCAH Standards**
10:30-11:30 A.M.—St. Mary's Hospital, Passaic
(AMNJ)

4 **Meeting: New Jersey Society of Physical Medicine and Rehabilitation**
6:30 P.M.—St. Lawrence Rehabilitation Center, Lawrenceville
(NJ Society of Physical Medicine and Rehabilitation)

5 **Appropriate Fluid IV Ordering, Electrolyte and Fluid Balance, TPN**
12 Noon-1 P.M.—Community Medical Center, Toms River
(Community Medical Center)

7 **8th Annual Clinical Update in**

Hahnemann University

Department of Medicine Grand Rounds
Wednesdays 8:30 a.m.-9:30 a.m.

Nov.-Dec. 1991

November 1991

November 6, 1991

TREATMENT OF HYPERLIPIDEMIA
David Bilheimer, M.D.
Professor of Medicine
University of Texas
Southwest Medical Center
Dallas, Texas

November 13, 1991

DIAGNOSIS AND TREATMENT OF BREAST CANCER
Isadore Brodsky, M.D.
Professor and Chairman
Department of Neoplastic Diseases
Hahnemann University
S. Benham Kahn, M.D.
Professor of Neoplastic Diseases
Department of Neoplastic Diseases
Hahnemann University

November 20, 1991

TREATMENT OF OSTEOPOROSIS
Robert Lindsay, M.D., Ph.D.
Professor of Clinical Medicine
Columbia University College of Physicians and Surgeons
Chief, Internal Medicine
Helen Hayes Hospital, NY

November 27, 1991

AIDS AND CARDIOVASCULAR COMPLICATIONS OF SUBSTANCE ABUSE
Vincent Zarro, M.D., Ph.D.
Professor of Medicine
Director, Division of Clinical Pharmacology
Hahnemann University

December 1991

December 4, 1991

DIASTOLIC MECHANISMS OF HEART FAILURE
Robert O. Bonow, M.D.
Chief, Nuclear Cardiology
Deputy Chief, Cardiology Branch
NHLBI, Bethesda, MD

December 11, 1991

THYROTOXICOSIS: A SPECTRUM OF DISEASE
Lewis E. Braverman, M.D.
Professor of Medicine and Physiology
Director, Division of Endocrinology
University of Massachusetts

December 18, 1991

IMMUNOLOGY AND RHEUMATOLOGY CLINICAL RESEARCH
Lawrence H. Brent, M.D.
Assistant Professor of Medicine
Division of Immunology and Rheumatology,
Hahnemann University
Carolyn H. McGrory, R.N., M.S.
Clinical Nurse Specialist
Division of Immunology and Rheumatology,
Hahnemann University

December 25, 1991

No Grand Rounds

Hahnemann University Department of Medicine
Wednesday Medical Seminar Series
8:30 a.m.-3:30 p.m.

November 6, 1991
TREATMENT OF HYPERLIPIDEMIA

November 13, 1991
DIAGNOSIS AND TREATMENT OF BREAST CANCER

November 20, 1991
TREATMENT OF OSTEOPOROSIS AND METAGOLIC BONE DISEASE

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Allan B. Schwartz, M.D.
Professor of Medicine
Director, Continuing Medical Education for the Department of Medicine

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Pulmonary Medicine
8 A.M.-5 P.M.—Caesar's Hotel and Conference Center, Atlantic City
(Deborah Heart and Lung Center)

9 **Costs of Health Care**
11:30 A.M.-1 P.M.—East Orange General Hospital, East Orange
(AMNJ)

9 **Chronic Epstein-Barr Virus**
1-2 P.M.—New Lisbon Developmental Center, New Lisbon
(AMNJ)

11 **Estrogen Replacement Therapy**
10:30-11:30 A.M.—St. Mary's Hospital, Passaic
(AMNJ)

11 **Diabetic Retinopathy**
1-2 P.M.—VA Medical Center, Lyons
(AMNJ and NJDOH)

18 **Pulmonary Grand Rounds**
11:30 A.M.-12:30 P.M.—Newcomb Medical Center, Vineland
(Newcomb Medical Center)

January

1 **Endocrine Monthly Meeting**
6-9 P.M.—Holiday Inn, Newark Airport, Newark
(AMNJ)

1 **Endocrinology Grand Rounds**
8 11:30 A.M.-1 P.M.—VA Medical
15 Center, East Orange
22 *(AMNJ)*
29

1 **Interhospital Endocrine**
8 **Rounds**
15 3:30-5:30 P.M.—Newark Beth
22 Israel Medical Center,
29 University Hospital, VA Medical Center, and United Hospitals Medical Center
(AMNJ)

3 **Health Promotion for People with Down's Syndrome**
12:30-1:30 P.M.—Somerset Medical Center, Somerville
(AMNJ and Developmental Disabilities Center)

6 **Occupational Asthma in New Jersey**
11:30 A.M.-1 P.M.—East Orange General Hospital, East Orange
(AMNJ)

8 **Diabetic Nephropathy**
11:30 A.M.-12:30 P.M.—Hamilton Hospital, Hamilton
(AMNJ)

8 **Prevention of Lower Extremity Amputations**
1-2 P.M.—VA Medical Center, Lyons
(AMNJ and NJDOH)

8 **Menopause**
10:30-11:30 A.M.—St. Mary's Hospital, Passaic
(AMNJ)

9 **Health Promotion for People with Down's Syndrome**
8:30-9:30 A.M.—St. Peter's Medical Center, New Brunswick
(AMNJ)

15 **Pulmonary Grand Rounds**
11:30 A.M.-12:30 P.M.—Newcomb Medical Center, Vineland
(AMNJ)

15 **Diabetes in Pregnancy**
1:30-2:30 P.M.—Central New Jersey Medical Group, Somerset
(AMNJ)

15 **Diabetes-Related Cardiovascular Disease**
10-11 A.M.—Hunterdon Developmental Center, Clinton
(AMNJ and NJDOH)

15 **Diabetes-Related Cardiovascular Disease**
11:30 A.M.-12:30 P.M.—Rahway Hospital, Rahway
(AMNJ and NJDOH)

15 **Thyroid Diseases**
2:30-3:30 P.M.—Ancora Psychiatric Hospital, Hammonton
(AMNJ)

15 **Intensive Review of Annual**
22 **Medicine**
29 4-7 P.M.—University Hospital, Medical Education Bldg., New Brunswick
(AMNJ and UMDNJ)

15 **Fluid and Electrolyte Imbalance**
10:30-11:30 A.M.—St. Mary's Hospital, Passaic
(AMNJ)

16 **Thyroid Dysfunction in Clinical Practice**
1:30-2:30 P.M.—Essex County Hospital Center, Cedar Grove
(AMNJ)

17 **Juvenile Onset Diabetes: Medical and Physical Aspects**
12 Noon-1 P.M.—South Jersey Hospital System, Bridgeton
(AMNJ)

17- **Winter Weekend: Family**
20 **Practice**
Great Gorge
(NJ Academy of Family Physicians)

22 **Hypertension**
2:30-3:30 P.M.—Ancora Psychiatric Hospital, Hammonton
(AMNJ)

27 **Anemia in the Elderly**
1-2 P.M.—New Lisbon Developmental Center, New Lisbon
(AMNJ)

28 **Health Promotion for People with Down's Syndrome**
8:30-9:30 A.M.—Newark Beth Israel Medical Center, Newark
(AMNJ)

29 **Diabetes-Related Cardiovascular Disease**
9-10 A.M.—Warren Hospital, Phillipsburg
(AMNJ and NJDOH)

ONCOLOGY & RADIATION ONCOLOGY

December

10 **Risk Factors for Oral Cancer**
12:15-1:30 P.M.—John Fitch Plaza, Trenton
(AMNJ and NJDOH)

5 **Tumor Board Conference**
12 12:15-1:15 P.M.—Mercer
19 Medical Center, Trenton
(Mercer Medical Center)

11 **13th Tumor Board Conference**
6 P.M.—Hyatt Regency, New Brunswick
(Oncology Society of New Jersey

19 **Cocktail Reception**
6:30-9 P.M.—Hyatt Regency, Route 27, New Brunswick
(Head and Neck Oncology Section, AMNJ)

January 1992

9 **Tumor Board Conference**
16 12:15-1:15 P.M.—Mercer
23 Medical Center, Trenton
30 *(Mercer Medical Center)*

22 **Cocktail Reception**
6:30-9 P.M.—The Manor, West Orange
(Radiation Oncology Section, AMNJ)

PHILADELPHIA HEART INSTITUTE

at Presbyterian Medical Center

Cardiology Update

designed for the physician and provides an intensive survey of the current status of clinical cardiology . . .

Wednesday, December 4, 1991

Cardiac Imaging—1992

Moderator: Ami E. Iskandrian, M.D.

3:00-3:30 Dissecting aneurysm: Angiography, echocardiography, MRI, CAT scanning—which, when and why?—***Harry G. Zegel, M.D.***

3:30-4:00 The role of nuclear studies in chronic coronary heart disease—***Ami E. Iskandrian, M.D.***

4:00-5:00 Case Presentations—***Steven Roberts, M.D.***
Panel Discussion—***Norman Feinsmith, M.D., Howard Rosner, D.O., Gary J. Vigilante, M.D.***

- *Case Presentations and Panel Discussions*
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The Philadelphia Heart Institute at Presbyterian Medical Center is an affiliate of the University of Pennsylvania.

**Presbyterian Medical Center designates this continued medical education activity for 2 credit hours in Category I of the Physicians' Recognition Award of the American Medical Association and the Pennsylvania Medical Society Membership requirement. Nine sessions, 18 credits.*

PSYCHIATRY

December

5 **Community Meeting as Large Group Psychotherapy**
12 Noon-1 P.M.—Carrier Foundation, Belle Mead
(Carrier Foundation)

12 **Medicolegal and Ethical Aspects of Prescribing Psychotropics**
12 Noon-1 P.M.—Carrier Foundation, Belle Mead
(Carrier Foundation)

13 **Geriatric Psychopharmacology**
10-11 A.M.—Marlboro Psychiatric Hospital, Marlboro
(AMNJ)

18 **Psychiatry: Compliance with Treatment**
2:30-3:30 P.M.—Ancora Psychiatric Hospital, Hammonton
(AMNJ)

19 **Outpatient Behavioral Therapy with Adolescents**
12 Noon-1 P.M.—Carrier Foundation, Belle Mead
(Carrier Foundation)

19 **CAT Scan, MRI, and PET in Psychiatric Disorders**
1:30-2:30 P.M.—Essex County Hospital Center, Cedar Grove
(AMNJ)

RADIOLOGY

December

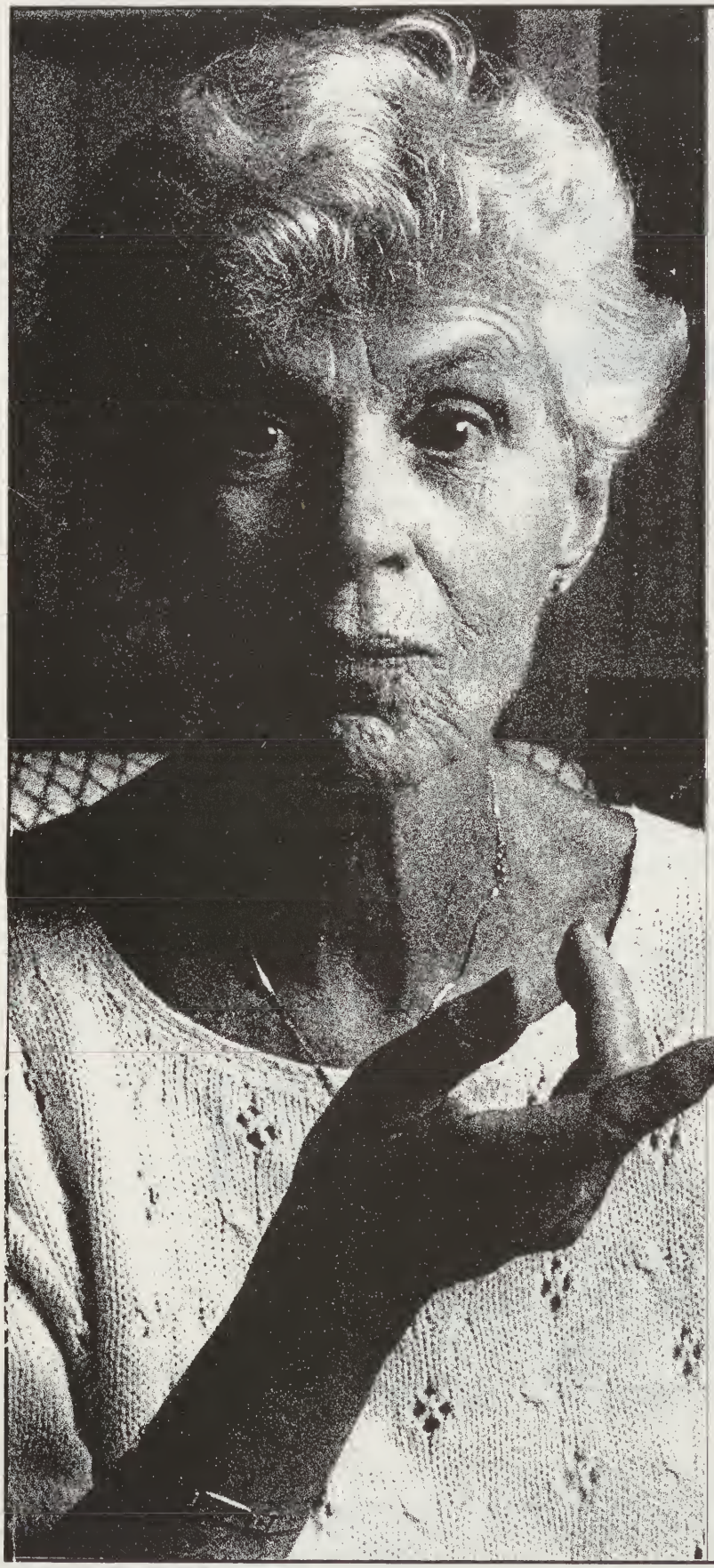
12 **MRI Conference and Case Presentation**
7:30-9:30 P.M.—Saint Barnabas Medical Center, Livingston
(NJ Institute of Ultrasound in Medicine, Radiological Society of New Jersey, and Diagnostic Radiology Section, AMNJ)

19 **Radiology Lecture**
1:30-5 P.M.—Saint Barnabas Medical Center, Livingston
(Saint Barnabas Medical Center)

January

16 **Small Bowel Disease: MRI Conference and Case Presentation**
7:30-9:30 P.M.—Saint Barnabas Medical Center, Livingston
(NJ Institute of Ultrasound in Medicine, Radiological Society of New Jersey, and Diagnostic Radiology Section, AMNJ)

16 **Radiology Lecture**
1:30-5 P.M.—Saint Barnabas Medical Center, Livingston
(Saint Barnabas Medical Center)



Here's why I'm against mandatory Medicare assignment...

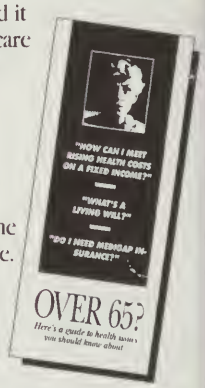
There's a lot of talk these days about making every doctor in New Jersey accept assignment for Medicare patients. While on the surface it sounds like a good idea for all doctors to accept what Medicare pays, it's a step that could actually have a negative impact on seniors.

First of all, it's simply not necessary. Seniors who need help meeting medical bills can get it easily through a voluntary program called Senior Medical Courtesy in which several thousand New Jersey doctors already participate. Through this program several thousand New Jersey doctors have agreed to accept what Medicare allows, billing the patient only for the 20% co-payment required by federal law.

Second, if I can afford to pay my fair share and don't, the cost of my care will be shifted to my children and grandchildren, who are struggling enough as it is. It doesn't seem fair to burden them further by putting them in a position to subsidize my care.

And finally, I want to keep all my options open. Right now, I have access to the best medical care available. But if the state imposes such a system on all seniors, even those who can afford to pay their own way, some doctors will find it difficult to continue seeing Medicare patients as they currently do. As a result, my care options might be limited.

When you put all the political double-talk aside, what you really have is a plan that's not only unnecessary, but actually against the best interests of seniors in our state.



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IN MEMORIAM

RANDOLPH A. LONDON

Born on November 6, 1920, in Brooklyn, Randolph Abraham London, MD, died on May 20, 1991, at the age of 70. Dr. London received a medical degree from Tulane University School of Medicine, New Orleans, in 1944. After serving as a captain in the United States Army from 1945 to 1947, Dr. London received his New Jersey medical license in 1948. A family practitioner, Dr. London practiced in North Bergen and Englewood, and was on staff at North Hudson Hospital, Weehawken; Christ Hospital, Jersey City; and Palisades General Hospital, North Bergen. Dr. London was a member of our Hudson County component and of the American Medical Association.

GERALD V. SCHOENBRUN

Watchung resident Gerald Victor Schoenbrun, MD, died on June 19, 1991, at the age of 67. He was born on December 4, 1923, in Brooklyn. Dr. Schoenbrun was awarded a medical degree from the State University of New York, in 1952, and he completed an internship at Cedars of Lebanon Hospital, Los Angeles, and residencies at Maimonides Hospital and at Bellevue Hospital, both in New York. He received his New York and New Jersey medical licenses in 1953 and 1957, respectively. Specializing in orthopedic surgery, Dr. Schoenbrun practiced in Plainfield for 31 years; he was attending at Muhlenberg Regional Medical Center, Plainfield, and a consultant at John E. Runnells Hospital, Berkeley Heights. Dr. Schoenbrun was a member of the American Medical Association, of our Union County component, of the New Jersey Orthopedic Society, and of the Watchung Board of Health. Dr. Schoenbrun was a World War II Army veteran. He retired in 1988.

SIDNEY L. SIEGEL

At the age of 82, Sidney Leon Siegel, MD, died on May 20, 1991. Dr. Siegel was born in Hoboken on December 20, 1908. He earned his medical degree from the University of Maryland, School of Medicine, Baltimore, in 1932. After receiving his New Jersey medical license in 1934, Dr. Siegel completed an internship at Jersey City Medical Center and a residency at Hudson County Meadowview Hospital, Secaucus. Specializing in cardiology and geriatrics, Dr. Siegel resided and practiced in Millville for over 50 years, serving on staff at Millville Hospital. Dr. Siegel was a member of our Cumberland County component, serving on the Executive Committee from 1944 to 1946, as president in 1947, and on the Judicial Committee from 1956 to 1959. He also was a member of the American Medical Association; president of the Cumberland County Heart Association in 1956; and a fellow of the American College of Cardiology.

PASQUALE A. STATILE

Pasquale Anthony Statile, MD, of Hackensack, passed away on May 27, 1991. Born on February 24, 1912, in Jersey City, Dr.

Statile was awarded his medical degree from Hahnemann Medical College, Philadelphia, in 1937. The following year he received his New Jersey medical license. Specializing in pediatrics and dermatology, Dr. Statile maintained a private practice in Jersey City for many years, and was affiliated with Jersey City Medical Center, Greenville Hospital, and Jewish Hospital and Rehabilitation Center, all in Jersey City. During his lengthy medical career, Dr. Statile served as director of dermatology at St. Francis Hospital, Jersey City, and as assistant director of the Jersey City Division of Medical Services. He was a diplomate of the American Board of Dermatology; a member of the American Medical Association, and of our Hudson County component; and a clinical instructor in pediatrics at New York University, New York. Dr. Statile resided in Jersey City before retiring to Hackensack 16 years ago. Dr. Statile was a World War II veteran.

WILBERT R. STAUB

Past-president of our Salem County component, Wilbert Robert Staub, MD, passed away on March 28, 1991. Dr. Staub was born on January 10, 1923, in New York City; he was awarded a medical degree from Marquette University School of Medicine, Milwaukee, Wisconsin, in 1946. Dr. Staub completed an internship at Muhlenberg Hospital, Plainfield, and a residency at Abington Memorial Hospital, Abington, Pennsylvania. After serving in the United States Army Medical Services from 1951 to 1953, Dr. Staub received his New Jersey medical license in 1954. An internist, Dr. Staub practiced in Salem; was chief of medicine and chief of staff at Memorial Hospital of Salem County, Salem; and was an assistant instructor in gastroenterology at the University of Pennsylvania School of Medicine, Philadelphia. Dr. Staub was a school physician for Jefferson School, Westfield, from 1953 to 1957; a member of the Board of Directors of the Westfield chapter, American Red Cross, and of the American Medical Association; a diplomate of the American Board of Internal Medicine; and a fellow of the American College of Physicians.

RALPH G. WOODRUFF

Englishtown resident, Ralph Galloway Woodruff, MD, died on March 19, 1991, at the age of 86. Dr. Woodruff was born in Sanford, Florida, on January 14, 1905. In 1930, Dr. Woodruff was awarded his medical degree from Jefferson Medical College, Philadelphia. The following year he received his New Jersey medical license. Dr. Woodruff, a general practitioner, maintained a private practice in Englishtown for many years. Dr. Woodruff was a member of our Monmouth County component and of the American Medical Association.

JOSHUA N. ZIMSKIND

At the grand age of 89, surgeon Joshua Norman Zimskind, MD, of Trenton passed away on June 8, 1991. On August 6, 1901, Dr. Zimskind was born in New York City. In 1927, Dr. Zimskind was awarded his medical degree from Jefferson Medical College of Philadelphia and received his New Jersey medical license the following year. He completed an internship at St. Francis Medical Center, Trenton. Dr. Zimskind practiced in Trenton for over 64 years and was chief of surgery at Mercer Medical Center, Trenton. He was president of our Mercer County component, a fellow of the American College of Surgeons, a member of the AMA, and a diplomate of the American Board of Surgeons.

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NEW JERSEY MEDICINE is the official organ of the Medical Society of New Jersey. The goals are educational and informational. All material published is copyrighted by the Medical Society of New Jersey.

The educational contents of each issue appear as scientific articles, based on research, original concepts relative to epidemiology of disease, and treatment methodology; case reports; review articles; clinical notes; state of the art reports; and special articles, that include evaluations, policy and position papers, and reviews of nonscientific subjects. Other topics include professional liability commentary; critical narration; medical history; pediatric briefs; nutrition update; and opinions. Editorials are prepared by the editor and by guest contributors on timely and relevant subjects. The Doctors' Notebook section contains organizational and administrative items from the Medical Society of New Jersey and from the community. Letters to the editor and book reviews are welcome and will be published as space permits.

The principal aim in the preparation of a contribution should be relevance to diagnosis and treatment and to the education of patients and professionals. Preference will be given to authors from New Jersey and to out-of-state lecturers submitting a suitable manuscript based on a presentation made to an audience in New Jersey.

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1. Goldwyn RM: Subcutaneous mastectomy. *NJ MED* 74:1050-1052, 1977.

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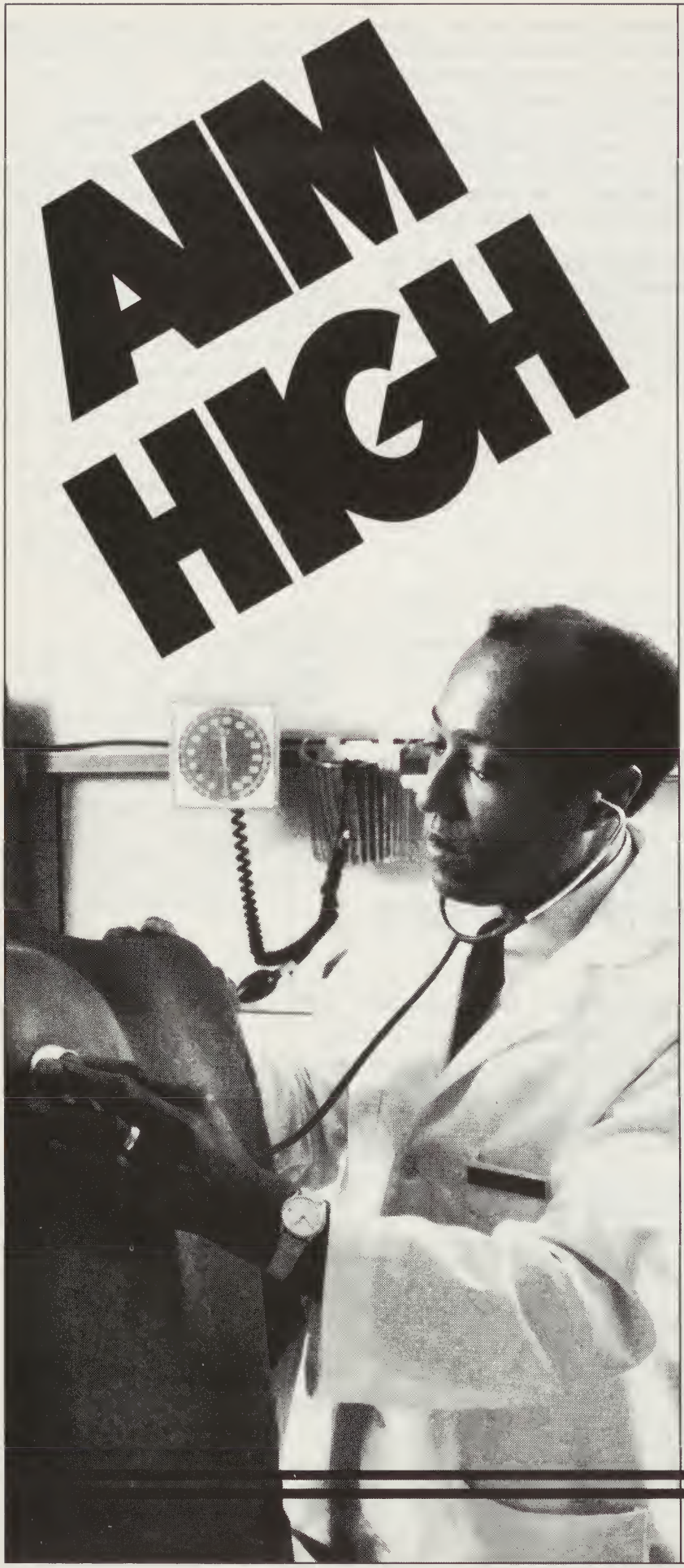
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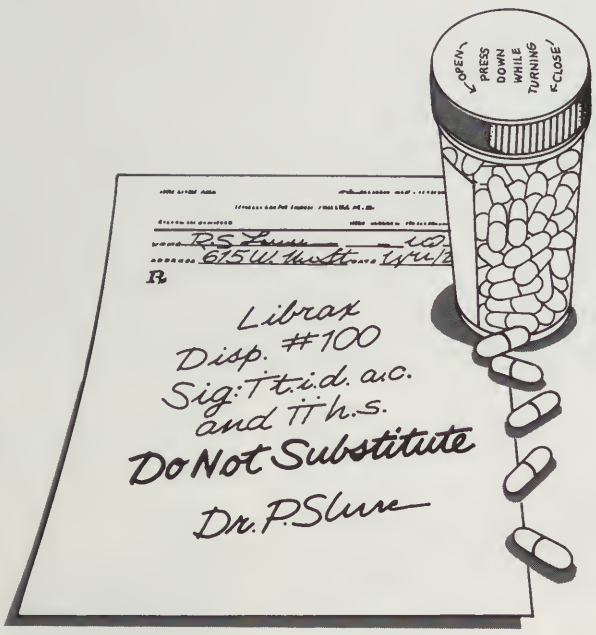
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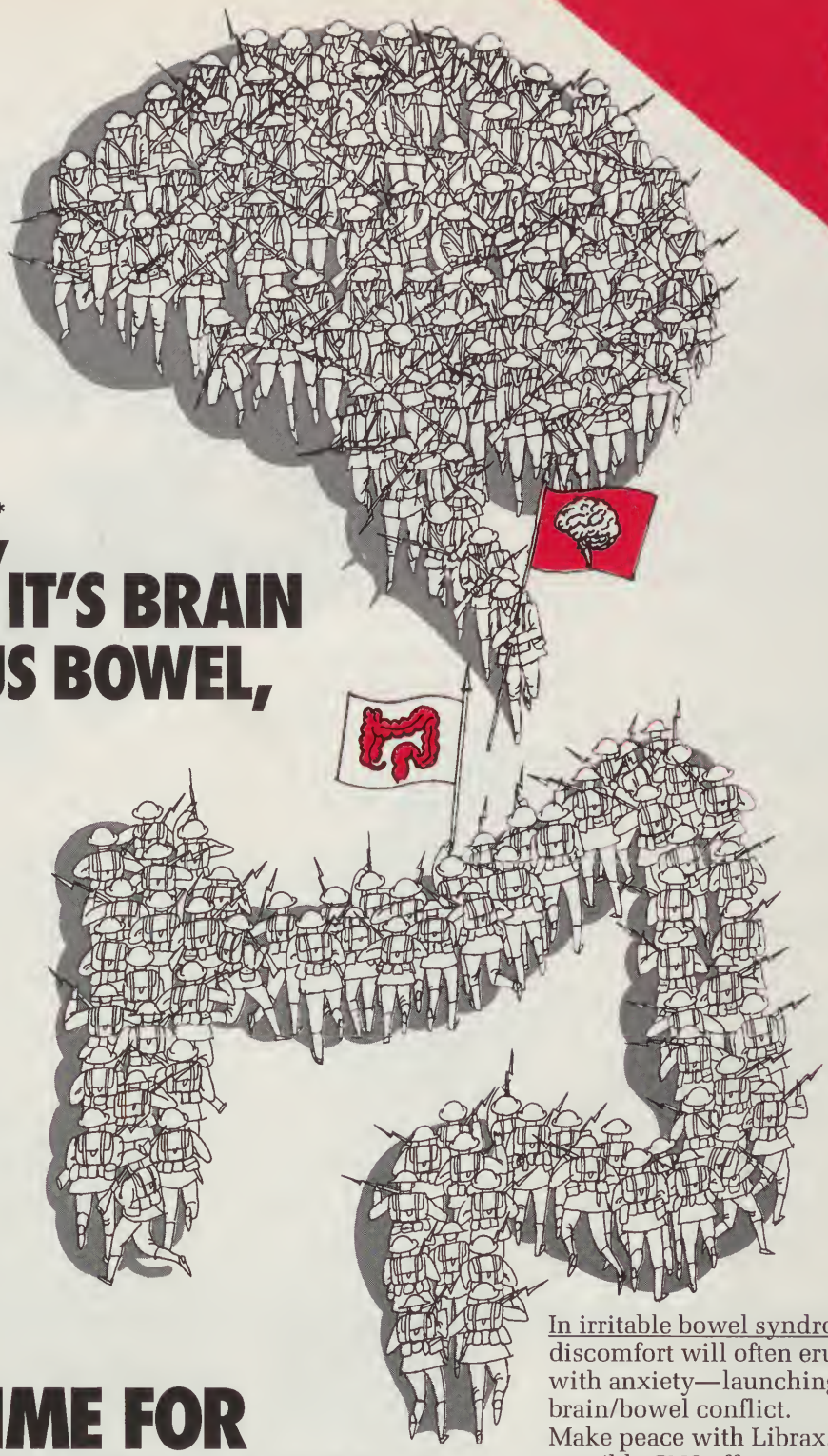
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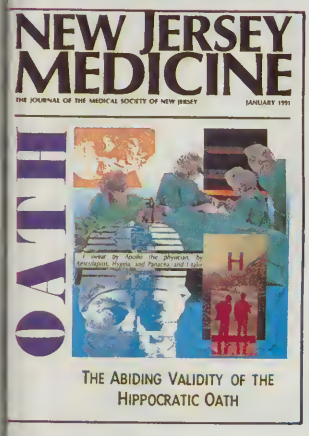
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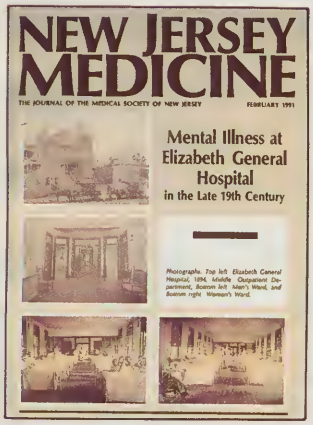
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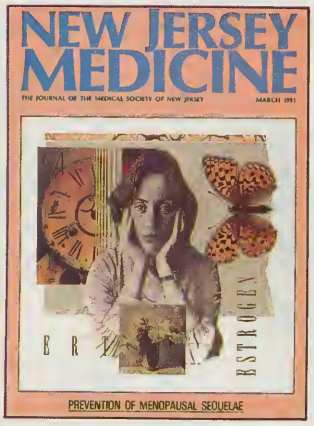
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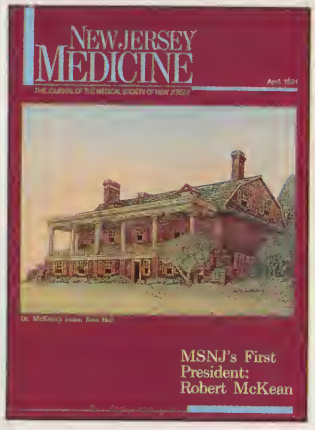
THE JOURNAL OF THE MEDICAL SOCIETY OF NEW JERSEY

December 1991

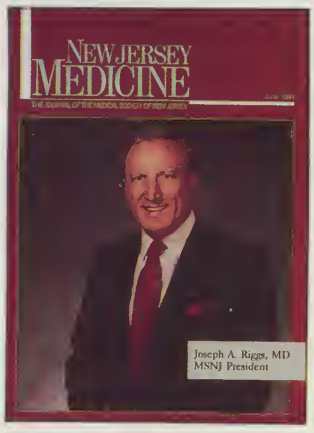


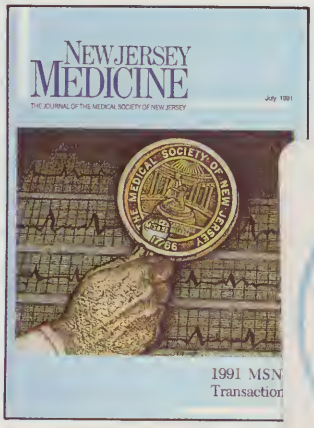






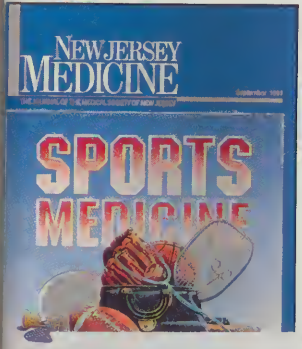


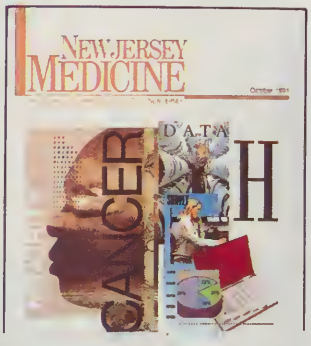


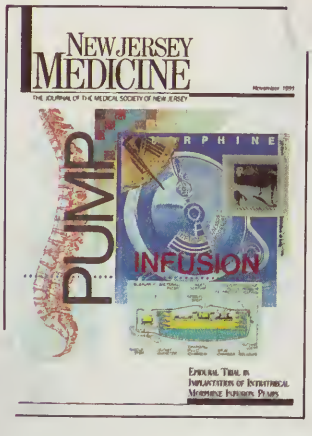




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Newswatch

INSURANCE COMPANY REQUESTS MEDICAL INFORMATION...

The State Board of Medical Examiners (SBME) takes a dim view of insurance companies making telephone requests for medical information. In a September 1991 letter to an Ocean County physician, SBME declared that the insurance companies should make their requests in writing and should provide the patient's written consent to the release. SBME further stated that the only exception would be emergent cases.

NO DISCRIMINATION AGAINST IMGs...

The Medical Society of New Jersey's Committee on International Medical Graduates (IMGs) met on November 6, 1991, with staff of the State Board of Medical Examiners (SBME). After receiving a full explanation of licensure procedures applicable to IMGs, the Committee was satisfied that SBME is not engaging in any discriminatory practices against IMGs. The Committee is chaired by Frank Campo, MD. Participating SBME staff members were Charles Janousek, executive director, and Katherine Carroll, assistant executive director.

MEDICAID PROVIDER UPDATES MUST BE FILED...

As part of a transition to a new fiscal agent, Unisys Corporation, the state Medicaid program, is requesting physicians to help assure the accuracy of its files. Correspondence from Unisys lists the physician's new seven-digit Medicaid number and other information. Physicians are strongly advised to use this number on all claims and to verify the accuracy of the other information.

HCFA TO ANNOUNCE FINAL RBRVS REGULATIONS...

Gail Wilensky, HCFA administrator, announced the final Medicare fee schedule regulations at the end of November 1991. MSNJ and the AMA will oppose any behavioral offset. NEWSWATCH will be published after the Health Care Financing Administration (HCFA) announces its action, but because of publication deadlines, we cannot anticipate the regulations. The AMA House of Delegates will determine its position at its meeting on December 10 and 11, 1991.

December 1991

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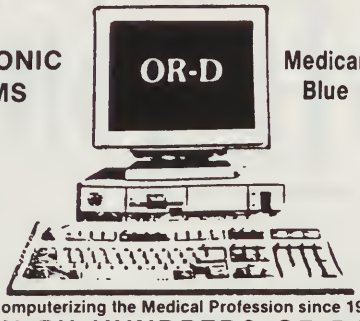
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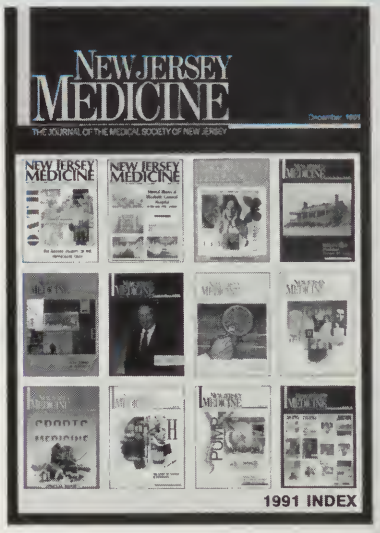
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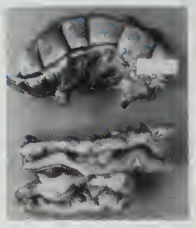
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The Cover

The 1991 year-end index is included in this issue, beginning on page 921. The journal also is abstracted in *Index Medicus*.

This is the first installment of *One to One*, a series that invites physicians to ask questions about the Medical Service Association of Pennsylvania, New Jersey's Medicare Part B carrier.

We've designed *One to One* to be another open line of communications between physicians and the Medicare carrier. Our goal is to give you the opportunity to ask questions — and to give us the chance to provide more physicians with information about our Medicare Operations.

Your questions will be addressed by Eileen M Moynihan, M.D., our Medicare Medical Director for New Jersey. In the first several installments of One to One, Dr. Moynihan answers some of the most commonly asked questions about Medicare.

If you have a question, please write Dr. Moynihan at: Medicare Part B, 133 Franklin Corner Rd., Lawrenceville, N.J., 08648.

One to One.

What is the relationship of the Medical Service Association of Pennsylvania to Medicare in New Jersey?

We have a contract with the federal Health Care Financing Administration (HCFA) to process Part B claims for New Jersey beneficiaries.

Part B or supplementary Medicare Insurance covers medical and surgical services by physicians. It also covers certain other health services such as ambulance transportation, durable medical equipment and independent laboratory services.

Part A covers facility charges. Companies that administrate Medicare Part A are known as fiscal intermediaries.

Our primary responsibilities as a Medicare carrier are to process Medicare claims promptly and efficiently, and to make payments as accurately as possible, based on the information supplied to us by beneficiaries and providers.

How long has your Company been involved with Medicare?

We have administered Medicare in Pennsylvania since the program became operational on July 1, 1966. Medicare was created under the Social Security Act that was signed into law by President Lyndon B. Johnson on July 30, 1965.

The Company became the New Jersey carrier in 1989, and the New Jersey carrier in 1989, and the carrier for Delaware and the Washington D.C. metropolitan area in 1981. There are 48 Medicare Part B carriers in the U.S.

How does the Medical Service Association of Pennsylvania profit from this relationship?

Like all Medicare carriers, we operate our Government Business activities on a non-profit basis with a tight budget supplied and controlled by HCFA. The budgets are constructed to pay just claims and administrative costs.

Efficient claims processing is essential, given the manner in which funds are allocated. Delays in claims processing, review and claim development are costly.

How does your Company handle Medicare, along with the administration of health care coverage for its private subscribers?

We are divided into two, separate business units. The Government Business Unit administers our Medicare contracts. And, the Private Business Unit handles our private insurance.

The largest processor of Medicare Part B claims, we serve 3.2 million Medicare beneficiaries, including over 1 million in New Jersey. The Company also serves nearly 6 million private subscribers.

Through our New Jersey Medicare contract, we work with 26,074 providers.

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MSNJ NEWSLETTER

AMBULATORY SURGICAL CENTERS

The Division of Medical Assistance and Health Services has submitted a proposed amendment to the *Independent Clinic Services Manual* (*N.J.A.C.* 10:66) to the Office of Administrative Law. The amendment will appear in a future issue of *New Jersey Register*. The amendment will establish a reimbursement schedule for ambulatory surgical center services comprising eight payment categories, in place of the present schedule for four categories. This payment structure applies only to the facility fee for these services. The complete text of the amendment will be found in a future issue of *New Jersey Register*.

The amendment, for the most part, is parallel to the Medicare structure for reimbursing ambulatory surgical center services. The categories, or payment levels, are listed in the proposed regulation. There are some procedures that Medicare does not cover, but which are covered by the New Jersey Medicaid program.

CERTIFICATES OF NEED

New Jersey's Health Care Administration Board (HCAB) has extended a statewide moratorium on all certificates of need (CN) through December 1992. HCAB, which now holds its regular meetings at the executive offices of the Medical Society of New Jersey in Lawrenceville, took the action on October 21, 1991.

Underlying the moratorium is the New Jersey State Department of Health's (NJDOH) effort to develop a new state health plan. Florio administration officials had requested an unlimited moratorium while the plan percolates. But HCAB members, almost all of whom are recent Florio appointees, insisted on a deadline.

The extension was adopted with only one dissenting vote. Shirley Girouard, RN, PhD, argued that NJDOH had failed to show that a moratorium would not adversely affect access to care. No physician or representative of organized medicine currently serves on HCAB.

POL WORKSHOPS

The key to quality testing in physician office laboratories is education. There will be a program on hematology testing and immunologic testing for physician office laboratory personnel and physicians on May 20, 1992. In addition, there will be a Red Cross cardiopulmonary resuscitation class during the day. For further information on this and other programs, please contact Ms. Kathleen Voldish, New Jersey State Advisor, American Society of Clinical Pathologists, 609/428-7652.

MEDICATION AWARENESS

The Hudson County Medical Society and the Hudson County Pharmaceutical Society cosponsored a program entitled, "Medication Awareness," for 400 senior citizens on October 23, 1991. This is the first time that two health care professional groups worked together on a project of tremendous importance to the senior citizen population. The featured speaker of the program was John

S. Madara, MD, a past-president of the Medical Society of New Jersey; he spoke on "Patients, Pills, and Physicians."

The program organizers hope to promote this program again, through the American Medical Association as well as through other county societies. The program was organized by Joseph N. Micale, MD, the first vice-president of the Medical Society of New Jersey and Edith Micale, a representative of the Pharmaceutical Society.

WRITING COMPETITION

The winner of our First Annual Writing Competition is Joseph G. Barone, MD, a resident in urology at UMDNJ-Robert Wood Johnson Medical School. Dr. Barone's paper, which will be published in a future issue of *NEW JERSEY MEDICINE,* concerns the Robert Wood Johnson pouch, a new technique for orthotopic bladder substitution that is relatively simple and eliminates the need to wear an appliance. Dr. Barone received a $500 prize for his entry.

NEW JERSEY MEDICINE will sponsor this contest next fall; it will be open to interns, residents, fellows, and students. Entrants need not be members of the Medical Society of New Jersey, but must be in training at a New Jersey hospital, studying at an institution in the state of New Jersey, or be a resident of New Jersey.

MCADD MEDICAL EDUCATION PROJECT

A statewide MCADD Medical Education Project has been established, with the goal of reaching New Jersey's physicians with information about medium-chain acyl-coenzyme A dehydrogenase deficiency (MCADD). The project is funded by the New Jersey State Department of Human Services' Office for Prevention of Mental Retardation and Developmental Disabilities and is being conducted by the Division of Neonatology of UMDNJ-Robert Wood Johnson Medical School and St. Peter's Medical Center.

MCADD, a potentially fatal genetic defect in fatty acid metabolism, accounts for a minimum of 2 to 3 percent of all deaths initially attributed to sudden infant death syndrome (SIDS) infants. The emerging body of knowledge about the clinical manifestations of MCADD, diagnostic procedures, and treatment approaches offers promising new directions in primary prevention and in managing families of SIDS infants.

The MCADD Medical Education Project will offer educational programs, grand rounds, and specialized seminars, and will prepare a bibliography of relevant readings and a pamphlet describing the biochemistry, diagnosis, and treatment of MCADD. New Jersey physicians are encouraged to contact the MCADD Medical Education Project at 908/745-6674 for information about MCADD and if they are interested in attending an educational program.

MEDICAID MANAGEMENT INFORMATION SYSTEM

A provider outreach letter will be forthcoming from Unisys. This letter from Unisys will request providers to verify that information on the Unisys provider file is current and complete. Please follow Unisys' instructions on updating their files if necessary. This letter also will include the newly assigned seven-digit Medicaid number. All claims submitted to Unisys must use this new number or they will not be processed.

The Division of Medical Assistance and Health Services also will be providing a series of Medicaid bulletins announcing dates of importance to all

providers in the days ahead. Do not prematurely submit claims to Unisys. This will result in a delay in processing claims. Unisys' mailbox officially opened and commenced processing claims on November 15, 1991.

GROUP PRACTICE PAYMENT LIMITS

One of the changes in Medicare reimbursement to take effect January 1, 1992, involves new physicians who work in group practices. Except for primary care services and rural areas, all physicians in years one through four of practice that include Medicare B will be subject to payment limits. Previously such limits did not apply to group practices. The new limits will be implemented through the fee schedule that replaces the customary charge basis of physician reimbursement.

HEALTH VOLUNTEERS OVERSEAS

Health Volunteers Overseas (HVO) is offering transportation subsidies, underwritten by the Marriott Foundation, to health professionals willing to spend at least one month practicing in an underserved foreign setting. Residents, fellows, and retirees are encouraged to apply. For details, call HVO at 202/296-0928.

DRUGS & THE ELDERLY

A newsletter on drugs and the elderly is being made available to subscribers at no charge. Named *UPDATE*, the quarterly for practitioners is prepared by the Gerontology Division of Beth Israel Hospital in Boston and Harvard Medical School. Support comes from the John A. Hartford Foundation of New York. Contact the Program for the Analysis of Clinical Strategies, 333 Longwood Avenue, 3rd floor, Boston, MA 02115, 617/732-1005; FAX, 617/735-8691.

AWARD WINNER GEORGE J. HILL

George J. Hill, MD, a member of our Essex County component, is the 1991 recipient of the Gorgas Medal for his outstanding career in cancer education.

ETHICAL ASPECTS OF ONCOLOGIC PRACTICE

Beginning on page 909, Dr. Rothberg provides clinicians with a set of "truisms" to serve as guiding principles for the care of cancer patients. It is difficult to find exception to these logical, straightforward ethical standards.

Consider, however, the perception of some observers that, as medical technology advances, concern for the individual patient's needs and desires may assume secondary importance. Somehow, individual wishes are subsumed by the "good of the whole," suggesting that society's good takes precedence over individual good. This is a thorny issue.

To address this, note the "backlash" of recent federal and state legislation intended to assure the individual his right to choose among treatment alternatives. If this were "standard operating procedure," why was legislation necessary to guarantee it? Perhaps the neat standards offered by Dr. Rothberg are not as clear or straightforward as we would like, or, are themselves subject to interpretation.

One might find principle number 5 arguable. What determines whether rational adults have a "right" to commit suicide? What circumstances allow a physician to aid or abet a patient's suicide? These questions are highly charged and far from settled, suggesting this may be a rather shaky principle. □ Alan J. Lippman, MD

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PROFESSIONAL LIABILITY

COURT DECISIONS

Risk of harm. In a major malpractice decision, a divided New Jersey Supreme Court ruled on September 4, 1991, that a verdict against physicians can stand even when none of the physicians is proved to have caused the patient's injury. All that the plaintiff needs to prove, said the court majority, is that the physicians negligently increased the risk of harm to the patient and that the increased risk helped cause the injury. The case before the high court involved a cataract procedure during which the patient sustained cardiac arrest that led to oxygen deprivation. After spending the next 13 months in a persistent vegetative state, the patient died.

A jury verdict against the physicians in the operating room and a consulting internist was reversed in the Appellate Division on the grounds that the plaintiff's expert witness had failed to establish both the relevant standard of care and causation. The Supreme Court, in this 4-3 decision, reversed the Appellate Division and ordered a new trial.

A plaintiff in a malpractice case must prove three elements: the standard of care owed by the defendant to the patient; the defendant's failure to achieve that standard; and proximate cause, that is, that the defendant's deviation from the standard of care resulted in injury to the plaintiff.

(Having proved malpractice, the plaintiff then must show monetary damages, such as loss of earnings, medical costs, pain and suffering, and—a topic explored in these pages last month—loss of enjoyment of life.)

Expert testimony is considered vital to prove these elements of malpractice. In this case, though, the expert testimony failed to show a causal link between the physicians' conduct and the patient's cardiac arrest. What the testimony did disclose was substantial confusion among the physicians, who did not know who among them was responsible for terminating the operation when the patient's condition became serious and her heart rate began to decline.

The Supreme Court's decision, authored by Justice Daniel J. O'Hern, also suggested that the jury may have been influenced by the defendants' explanations of events. For example, when asked about the declining heart rate, one of the defendants testified: "If it was an athletic person, a slowed heart rate doesn't mean that much." The patient, a 65-year-old woman of average height, weighed 340 pounds.

In dissent, Justice Stewart G. Pollock argued that the decision afforded the plaintiff "a second chance" to prove elements that were not satisfactorily demonstrated at trial. The dissent emphasized that previous rulings in favor of "increased risk" applied that concept prospectively only, as a way of computing damages. Seen in this light, the majority decision could substantially enhance physicians' vulnerability to malpractice claims.

However, the decision made no claim of extending the theory of increased risk. It is possible that the unusual facts of this case, such as the confusion among the defendants and a fatality in a routine surgical case, may sharply limit the effect of the decision.

Joining Justice O'Hern in the majority were Chief Justice Robert N. Wilentz and Justices Alan B. Handler and Gary S. Stein. Justices Robert L. Clifford and Marie L. Garibaldi joined Justice Pollock in dissent.

Action for battery. From California, comes other adverse news for physicians. A state appeals court permitted damages for battery to be sustained against a plastic surgeon in a breast reduction case. After each of two operations, the patient complained that her breasts were still too large. When the surgeon performed a more extensive procedure, which allegedly resulted in flattened breasts, the patient brought an action for battery.

Battery is considered an "intentional" tort, in contrast to negligence. Battery, defined as an "unauthorized touching," is found when a physician fails to obtain the patient's informed consent to a medical or surgical procedure. In California, the consequence of a battery action is that a state cap on malpractice damages does not apply. In this case the result was a $600,000 verdict. *Szkorla v. Vecchione,* 283 Cal. Rptr. 219 (Ct. App. 4th Dist., 1991).

Radiation treatment. Another California court ruled in favor of a physician and other defendants, however, in one aspect of a case involving a radiation overdose. Negligence was cited in the death of the patient, age nine, whose cancer was considered curable.

The question before the court was whether the parents, who were with the patient when the radiation was administered, could recover for emotional distress, to supplement other damages. Because the overdose was identified later on, so that the parents were unaware of the injury while they were witnessing the procedure, the court dismissed the claim of emotional distress. *Goldstein v. San Francisco Superior Court,* 273 Cal. Rptr. 270 (Cal. Ct. of App., 1990).

MALPRACTICE VERDICTS

Failure to diagnose. An emergency department physician's failure to diagnose carbon monoxide (CO) poisoning or admit the patient to the hospital led to a $500,000 verdict in a New Jersey courtroom in July. The plaintiff had presented with her mother, and the physician discharged the patient with a diagnosis of influenza while admitting the mother for pneumonia.

The plaintiff presented with a history of syncope and lethargy, low oxygen levels in the blood, disorientation, and possible loss of consciousness, while the mother's symptoms included difficulty in breathing, diffuse pins and needles sensations, and significant vomiting. During the night following discharge, the plaintiff's teen-aged daughter died of effects of CO poisoning, and the plaintiff sustained permanent brain damage. All three family members lived in a house with a blocked chimney.

As a result of her injury, the plaintiff was determined unable to pass competitive promotional examinations at work. The jury found the defendant 17.5 percent liable for the $500,000 damage award. Other defendants, involved with the furnace, were found liable for the remainder but had settled with the plaintiff before trial.

The defense in the case had attempted to show that CO poisoning is very rare and that the symptoms were quite general. But, the plaintiff's arguments stressed the seriousness of the constellation of symptoms.

The trial judge dismissed a claim against the physician for wrongful death of the plaintiff's daughter, ruling that the physician did not owe her a duty of care. The daughter had not visited the emergency department.

Cardiac care. A cardiovascular surgeon was found not negligent by an Essex County jury in March for not removing a pace wire from a patient's heart. Four pace wires were embedded during a six-vessel coronary bypass procedure. Three wires were removed within several days as planned, but the surgeon kept the last wire in place because, he said, the suture had not dissolved and traction could endanger the patient's life. Signs of infection allegedly developed 14 days postoperatively, and osteomyelitis developed, necessitating the removal of the sternum. Four years later, the patient died of unrelated prostate cancer.

The physician's failure to document the remaining wire was an issue in the case. He argued that a notation in the medical record was unnecessary, because the wire would be clearly observable by x-ray. He further contended that the osteomyelitis probably was not caused by the presence of the wire, since the infection occurred in another area.

Steroid injection. Another verdict for the defense was won in Camden County in June by a family physician. A patient suffered an indentation in the buttocks following a steroid injection administered to treat diverse food allergies. The patient contended that a more conservative approach should have been taken.

The defense noted that the patient returned for a second injection even after the indentation appeared. The jury found the physician not negligent. The jury also decided that the physician should have informed the patient of the risk of indentation, but that the physician's conduct did not cause the patient's injury.

Fibroid tumor. An obstetrician did not negligently advise a patient with a benign fibroid tumor to obtain an abortion, another New Jersey jury ruled in July. The tumor was detected by ultrasound two months before the patient, in her mid-30s, became pregnant. The patient and physician disagreed about whether he had advised her to consider waiting to see how the pregnancy progressed.

REIMBURSEMENT

RBRVS. The conservative Heritage Foundation, which has heavily influenced Republican Party policies for the past decade, has come out strongly against resource-based relative value scales (RBRVS). RBRVS, an approach to physician Medicare reimbursement, would shift payments slightly from surgeons toward primary care physicians. The Bush administration's proposal for implementing RBRVS has encountered the wrath of organized medicine due to an estimated 16 percent cut in reimbursement.

A 22-page report authored by Robert E. Moffitt, PhD, deputy director of domestic policy studies at the Foundation's Thomas A. Roe Institute for Economic Policy Studies in Washington, DC, calls RBRVS a form of price controls that would drive physicians away from caring for seniors. The report stresses that RBRVS-based fees would be economically unsound, in that they would not be tied to the value of the service as perceived by the patient.

The Heritage Foundation report castigates organized medicine for initially agreeing with the RBRVS concept. The report predicts a wave of interspecialty jockeying for higher fee levels. It heavyhandedly notes that this price control approach is being taken at the same time that Eastern European countries are turning away from economic regulation.

The report recommends requiring fee disclosure by physicians to patients. It further recommends allowing physicians to contract independently with seniors at

negotiated fees. The report is dated September 23, 1991, and is titled "Comparable Worth for Doctors: A Severe Case of Government Malpractice."

Also in September, the federal Physician Payment Review Commission (PPRC) unsheathed plans for studying the effects of RBRVS on seniors' access to care. Using a research method that rapidly is gaining currency, the PPRC will review hospital admissions data to determine whether more patients than before are admitted for selected conditions, such as hypertension, that can be prevented through earlier intervention.

Additionally PPRC researchers plan to compare changes in utilization between services for which reimbursement is being cut and services for which reimbursement remains stable. Furthermore, seniors will be surveyed to determine their pre- and post-RBRVS satisfaction with access and quality of care.

Physician services. The Urban Institute, a Washington think tank that has worked extensively on health policy issues, has reported that controls on hospital expenditures have not led to increases in physician expenditures. The researchers reviewed data from 1983 to 1985. The only observed exceptions were radiology and laboratory services, which tended to shift from inpatient to outpatient settings.

Significant in the Urban Institute study is the conclusion that increases in the volume of physician services under Medicare are attributable mainly to the aging population. Another key factor causing physician services to rise is the increase in Medicare assignment rates, which led seniors to visit physicians more often. (Holahan J, Dor A, Zuckerman S: Has PPS increased Medicare expenditures on physicians? *J Health Polit Policy Law* 16:335-362, 1991.)

Cost of administration. Administrative expenses—the bane of doctors and hospitals—were estimated in a September 1991 article by Doctors David Shulkin, Irving Williams, and William Cooper, published in *Pennsylvania Medicine,* the journal of the Pennsylvania Medical Society. Physicians' overall administrative expenses in our neighbor commonwealth were pegged at $14 to $17 million annually. The authors calculated total costs of compliance with Pennsylvania's 1986 Health Care Cost-Containment Act at $19 million.

Noted in the journal article was the overall burden of administrative costs, which are believed to have risen nationally from 21.9 percent of total health expenditures in 1983 to 23.9 percent in 1987. The average physician in the United States has 1.47 clinical and management workers at a cost of $51,564 per physician.

Administrative expenses are a double-edged sword in the debate over health care costs. The costs are so great that a change in the system appears indicated. However, advocates of national health insurance point to high administrative costs in the United States health care system as a reason to move to national health insurance, on the theory (that one might dispute) that a single payer would generate less paperwork.

Reimbursement levels. American Medical Association researchers have proposed a new mechanism for computing the Medicare Volume Performance Standard, which is used as a target in determining physician reimbursement levels. If the volume of services exceeds the target, reimbursement levels are reduced. (This is analogous to the "behavior offset" in the RBRVS proposal.) The AMA proposes that increases in demand, as noted in the Urban Institute study, should be considered in the calculations. The AMA view was summarized in *Federation Outreach Report* #91-28, issued on October 8, 1991.

Laboratory work. HCFA did suffer a temporary setback in its fraud-and-abuse campaign. In March, a federal administrative law judge ruled that physicians could establish clinical laboratories with partnership interests offered only to physicians who were in a position to refer business to the laboratories, even when most of the work was performed by an outside commercial laboratory, SmithKline Bioscience. The judge ruled that the California ventures did not actually require the partners to refer business to the laboratories. However, the case was sent back by the Department of Health and Human Services Appeals Board for reconsideration.

BIOMEDICAL ETHICS

Advance directives. A family feud has threatened to complicate New Jersey case law on advance directives. Since 1982, Thomas Smerdon, now 48, has been in a Toms River nursing home in a persistent vegetative state. His wife, Barbara, three oldest children, half-brother, and a sister support a court order authorizing Mrs. Smerdon to order the removal of a surgical feeding tube. Mr. Smerdon's mother and another sister, however, have been working with their lawyer, the president of the New Jersey Right-to-Life Committee, to oppose the order.

Recently allegations arose that Mrs. Smerdon has had one or more extramarital affairs that presumably influence her desire to end the life support. The court order was affirmed in the Appellate Division but now is pending review. Mrs. Smerdon's lawyer argues that, if his client were motivated by ill will or a desire to be extricated from her marriage, divorce would be a simpler solution than bitter litigation over advance directives.

LICENSURE

Reinstatement. Kansas's Supreme Court has permitted a state licensing board to refuse to reinstate a physician's license. The Board had revoked the license for numerous reasons and refused reinstatement due to the seriousness of the charges, the fact that the revocation had been in place for only 15 months, and the lack of evidence of rehabilitation. *Vakas v. Kansas Board of Healing Arts,* 808 P.2d 1355 (Kan. Sup. Ct., 1991).

The Kansas case, reviewed in a recent issue of *Citation,* a national medicolegal digest, focused on courts' tendency to sustain licensing board decisions. An exception took place in Florida, but even there the court decision went against the physician. Five of a psychiatrist's former patients testified that he used his position to persuade them into sexual relations with him.

In defense, the psychiatrist produced evidence about the patients' past sexual activities. An appellate court ruled the evidence of sexual history irrelevant. As a result of the court decision, the State Board of Medicine must reconsider its decision to take no disciplinary action against the physician.

Licensing examination. An Agreement Establishing the United States Medical Licensing Examination (USMLE) was signed in Washington, DC, on August 12, 1991, by representatives of the Federation of State Medical Boards (FSMB) and the National Board of Medical Examiners (NBME). Starting in June 1992, the three-step USMLE will replace both the NBME and FLEX examinations. In September 1991, the valedictory issue of the *FSMBNEWSLETTER* intoned: "At last the future is signed and sealed."

DENIAL OF PRIVILEGES

Hospital privileges. A cardiologist who was denied staff privileges at a New Jersey hospital won an award for punitive and compensatory damages. In a trial judge's oral decision in June, the award was set at $50,000 for punitive damages, based on a finding of malice, and $180,000 for compensatory damages, based on two years of lost income.

According to the judge, the chief of the hospital's cardiology section repeatedly told the cardiologist that there were no openings in the section—while applications from other physicians, associated with a perceived network of section members, were being entertained. There apparently was no dispute about the qualifications of the plaintiff, who eventually was admitted by the unanimous vote of an ad hoc committee of the hospital medical board.

The judge used strong language in declaring that the section chief "lied" to and deceived the plaintiff. The chief and the hospital were cited for the compensatory damages, and the chief alone was ordered to pay the punitive damages.

A certified registered nurse anesthetist (CRNA) lost privileges at a California hospital, and the hospital decision was upheld by a federal court of appeals in March. In response to surgeons' complaints about the lack of 24-hour coverage by anesthesiologists, the hospital decided to limit anesthesia privileges to anesthesiologists.

The hospital had only 49 beds, and at least one other area hospital offered CRNA privileges. Rather than restricting competition, as alleged by the CRNA, the hospital's action thus actually may have enhanced consumer choice.

MALPRACTICE POLICY DEVELOPMENTS

Tort system. A Chicago lawyer associated with American Lawyer Media has responded to Vice-President Dan Quayle's attack on the tort system, as reported in these pages last month. Among Philip H. Corboy's arguments:

- Tort suits have not dramatically increased. Instead, the great increase in lawsuits involves other types of cases.
- Many tort actions were initiated by the Reagan administration, in attempts to deny Social Security disability benefits, recover veterans benefits, and collect on student loans.
- Most dangerous product tort suits filed in federal court last year involved asbestos, which industry and the federal government used despite health warnings.
- Punitive damages in tort suits are rare and modest, according to a Rand Corporation study.
- Tort reform will not make firms in the United States more competitive, because foreign companies doing business in the United States must follow the same rules.
- The contingent-fee system discourages lawyers from taking cases that have no merit.
- The Constitution "was not designed to guarantee access to markets; it guarantees access to justice."

Mr. Corboy's letter was reproduced in *New Jersey Law Journal* on September 26, 1991.

PROFESSIONAL LIABILITY

This column is authored by James E. George, MD, JD, director of Professional Liability Control, and Neil E. Weisfeld, JD, MSHyg, director of Education, Research & Regulatory Affairs. □

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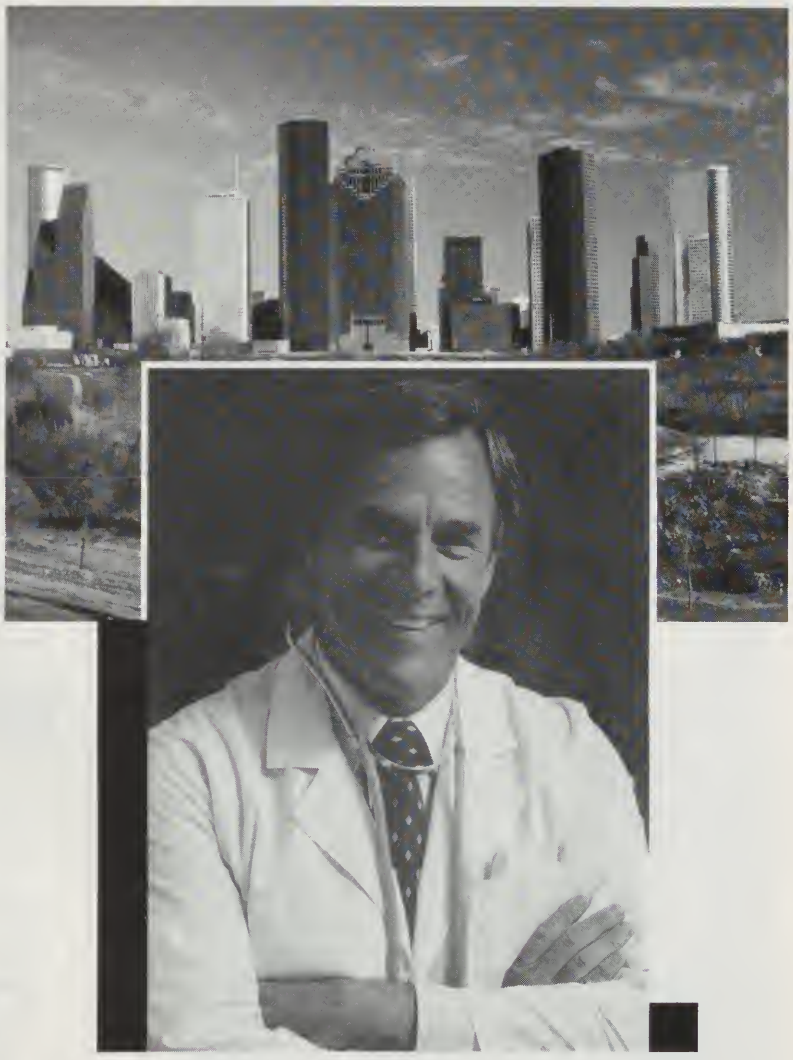
"After years of study, I honestly believed that I was ready to go into practice. I thought that knowledge and experience in medicine was all that I'd need to be a success out there. But, no one ever mentioned that I'd have to be an expert at insurance, law and collections...I'm a doctor, with a substantial amount of money and time invested in being the best that I can be. It didn't take long for me to realize that the time spent in managing my business was time taken away from the really important things in life; my patients, my family, and myself."

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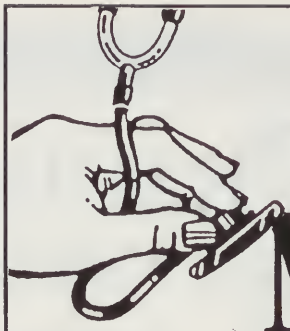
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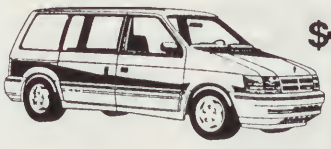
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BOOK REVIEWS

CODES OF PROFESSIONAL RESPONSIBILITY

Renal A. Gorlin. Washington, DC, BNA Books, 1990. Codes of Professional Responsibility reflects the increased public awareness of the ethical conduct of authorities from all walks of life. This second edition has been revised and updated; the original volume was published in 1986. The text includes organizational codes from 37 associations and has over 350 additional references on ethics for a variety of social groups. The table of contents covers accounting, advertising, architecture, banking, engineering, insurance, generalism, dentistry, medicine, nursing, and law. This book is essential for any professional and serves as a frame of reference for professionals considered experts in specific social situations such as those in the "practice of medicine." The focus on health and medicine is given by the Counsel of Ethical and Judicial Affairs of the American Medical Association. The chapter is well written and gives the historical background as well as the actual principles. The historical aspects of each of the codes are as important as the codes themselves. I highly recommend this textbook for students, sophisticates, and the general public. □
Leonard Bielory, MD

EXERCISE CAN BEAT ARTHRITIS

A View Video, Inc. Release. New York, NY, 1991. This particular videotape, originating in Australia, deserves serious consideration as an adjunct to the treatment and rehabilitation of the arthritis patient.

Studies have shown the importance of keeping the patient with arthritis mobile and out of a wheelchair. While this may not be possible with every patient, especially those who have been allowed to vegetate too long, exercise begun early in the disease can postpone or even prevent immobility. It is vital, however, that the correct type of exercise, based on the patient's current status, be prescribed.

This exercise tape, featuring nine groups of low-impact aerobic exercises, was made under the supervision of Valerie Sayce, a physical therapist at the Arthritis Foundation of Victoria, Australia. It is pleasant and easy to follow, set to music, and has appropriate warnings on the screen when certain flexion exercises are used that might not be appropriate for patients with severe spinal involvement.

The tape is accompanied by a booklet that discusses the benefits of exercise and explains arthritis, the anatomy of the joints, and each exercise group. It lists "do's and don't's" as well as suggesting consultation with the physician if in doubt about whether or not a particular exercise is appropriate.

The tape is reasonably priced ($24.98) and can be obtained by calling 1/800/843-9843. □
Christine E. Haycock, MD

IMMUNOTHERAPY WITH INTRAVENOUS IMMUNOGLOBULINS

Paul Imbach. New York, NY, Academic Press, 1991. This book is the third in a series of conference proceedings devoted to the specific uses of intravenous immunoglobulin for a variety of immunodeficiencies and immunological and autoimmune disorders. Immunology has grown from the area of antitoxins and

serum sickness to a state where the study of many diverse cells and molecules have become integrated into a coherent scientific discipline. This book has brought together the specific interests in uses of intravenous gamma globulin from chronic fatigue syndrome to more specific and definite entities of well-recognized immunodeficiencies. There are sections dedicated to general aspects of intravenous gamma globulin neonatal infections, secondary immunodeficiencies and infections, autoimmune disorders, and new prospective indications for the use of intravenous gamma globulin. This book also includes the abstracts presented at the conference. The book is appropriate for practicing clinicians as well as researchers interested in the clinical protocols available using intravenous gamma globulin. ☐ Leonard Bielory, MD

MRI ATLAS OF NEONATAL BRAIN DEVELOPMENT

A. James Barkovich; Charles L. Truwit. New York, NY, Raven Press, 1990. This easy-to-use pocket atlas skillfully navigates the complexities of magnetic resonance imaging (MRI) as it relates to the study of brain maturation. The subject matter is condensed into four key areas: brain maturation, corpus callosum, development of skull bone marrow, and development of brain iron.

The first chapter charts the maturation stages of the brain's white matter, utilizing a generous number of multiplanar scans. While the format of the next two sections, the corpus callosum and the bone marrow of the brain, invokes a structure similar to that of the first chapter, the exposition relies solely on sagital images—and rightly so. At six pages in length, the final chapter on the development of brain iron highlights this area.

I consider this reference guide, *Practical MRI Atlas of Neonatal Brain Development,* to be well constructed and highly readable. It should prove to be popular among radiologists, neurologists, and pediatricians. ☐ Neil B. Horner, MD

TRANSPLANTATION AND CLINICAL IMMUNOLOGY

J.L. Touraine; J. Traeger; A. Bétuel; J.M. Dubernard; J.P. Revillard; P. Daudon. New York, NY, Excerpta Medica, 1990. This book, *Transplantation and Clinical Immunology XXI: Late Failures and Chronic Rejection in Organ Failures,* is the proceedings of a meeting held in Lyon, Paris, France, in 1989. The book covers the general aspects and pathology of chronic rejection, experimental models and pathophysiology, histocompatibility, clinical aspects, and therapy. The text is a collage of individual oral presentations as well as poster presentations given at the symposium. They are focused on the immunology of rejection associated with renal cardiac, and liver transplants. The articles appear nonhomogenous, i.e. some are very specific and some superficial. However, the text is not meant to be a clinical one and is more focused on the immunobiology of organ transplants with elaboration of specific animal models. There is only a small section related to histocapability and the section related to the clinical aspects of therapy are clearly reflective of experimental management of late graft failure. There is an extensive listing of posters with a variety of specific points raised.

This book should be viewed as a collection of the proceedings of the symposium supported by a grant from the Mèrieux Foundation and not as a classical text in the area of transplantation and clinical immunology. ☐ Leonard Bielory, MD

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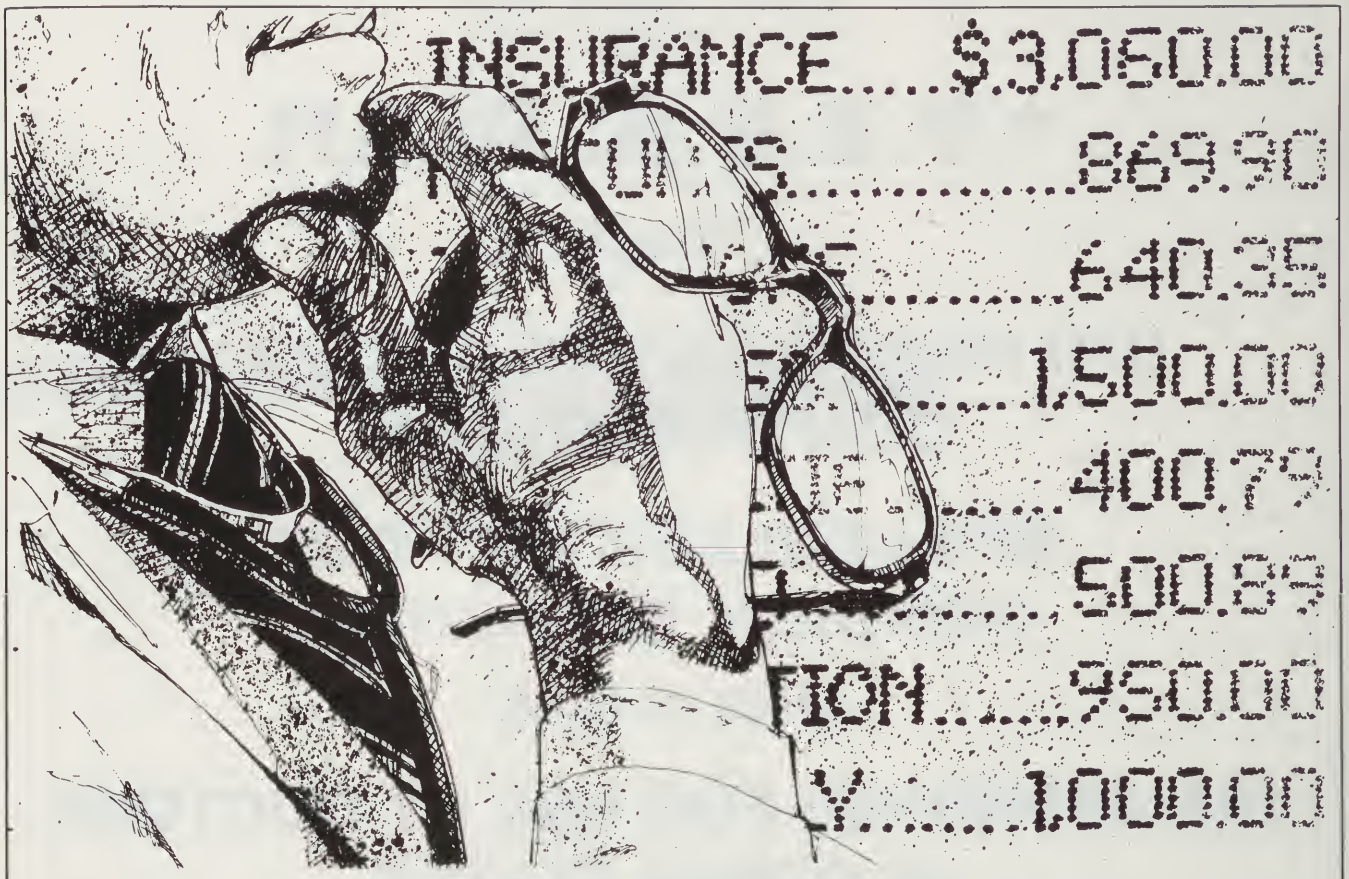
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LETTERS AND VIEWPOINTS

FIGHTING AIDS

We all agree that AIDS is the scourge of the 20th century. It certainly is as feared and devastating as the Black Plague that swept the earth in the Middle Ages. Unfortunately, mankind's approach to this social tragedy is firmly fixed in a Dark Age mentality. It is vital for our success in combating this disease to dispense with prejudicial attitudes and the misguided obsequious reverence for the so-called rights of special interest groups.

In order to control the disease, it is essential that potential sufferers be identified and appropriate measures be taken to treat, counsel, and apply certain restrictive measures. Therefore, it is patently obvious that mandatory testing is a cornerstone of any effort to control the spread of AIDS. There is historical precedent for mandatory testing, as evidenced by routine prenuptial testing for syphilis.

Organized medicine has indicated its feelings in this regard, and has suggested that mandatory testing be extended to all hospital patients. One would suggest that this be extended to all high-risk groups, and become a premarital requirement. Clearly, the rights of the individual must be protected and attention to confidentiality is paramount. As soon as an individual is tested positive, appropriate treatment and counseling can be carried out. Also, health caregivers then can take suitable precautions to avoid personal contamination and further spread. This stance is appropriate for reasons of containment, but also has moral justification, as the health care professional is legally obliged to render treatment to AIDS sufferers without option to refuse.

While exposure to AIDS is considered to be an occupational hazard, the spread of AIDS by a health caregiver to the public also is a concern that needs to be addressed. Just as mandatory testing is recommended for patients, it also should be extended, on a routine basis, to health caregivers. The recent public exposure of an AIDS-suffering physician and dentist and the catastrophic consequence on their ability to earn a living, is likely to provoke insurmountable resistance to this proposal. One would venture a solution that would make this approach more palatable.

It is suggested that a compensation fund for AIDS-affected health professionals be established. Contributions to this fund can be derived from health insurance policies, worker's compension payments, state general revenues, and licensing fees. With the fear of loss of their livelihood being removed there can be little objection to mandatory testing of health caregivers. This would act to ensure public confidence in the medical community and weaken the objections to universal testing.

It is only by such innovative approaches and discarding shibboleths that society can meet the challenge of this disease. ☐ Ian D. Samson, MD

BATTERY BURN

During a housecall, I examined a diabetic 56-year-old patient with a blackened burn on her upper thigh. She had taken a 9 volt transistor radio battery out of its cardboard/blister container and put it, uncovered, in her pocket. She felt heat, but it was too late: she went to an emergency room with a blistered burn. Being deeper than expected at first, it had not healed several weeks later.

Unlike D, C, or AA size batteries, whose positive and negative terminals are on opposite ends, 9 volt batteries have both terminals on the same end, and can be shorted by the smallest coins or metal objects in the same pocket. The small print on the package warns against leaving the battery uncovered in the pocket. It is unfortunate that one pole of the battery does not have an extra plastic shield to pop off, like the cap on a medicine bottle, as a final protection.

It is an implied compliment to the battery maker that there is enough energy in this battery (an alkaline cell) to generate so much heat that a burn can result.

I continue my comments of the medical danger. Children do not have the slightest idea of the energy stored in their transistor radio batteries, or the danger if loose in a pocket with coins. A pictorial warning would be better than the fine print currently used; the picture would be seen by the unsuspecting of all ages.

Whenever you see a 9 volt battery, remember the formula "battery open + pocket coins = burn" as a safety habit. ☐ Morris Soled, MD

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EDITOR'S DESK



E PLURIBUS UNUM

On October 23, 1991, I sat enthralled in the State Theater in New Brunswick, listening to the Tokyo Metropolitan Symphony Orchestra, conducted by Kazuyoshi Akiyama. The performance was exhilarating and the audience responded with thunderous applause.

On Sunday, December 7, 1941, many on the East Coast were listening to the radio play-by-play of professional football when the broadcasts were interrupted by the news of thunder in the Pacific. At 0600 hours on that day, 368 Japanese bombers and fighter planes pulled away from Admiral Nagumo's task force. Five echelons attacked Pearl Harbor at 0755 and 0900 hours, inflicting millions of dollars in damage, killing thousands of personnel, and sinking or crippling 19 ships, including all our battleships except the dry-docked *Pennsylvania;* only 19 Japanese planes were lost.

The following day President Roosevelt, declaring December 7, 1941, "a date that will live in infamy," proclaimed the existence of war between the United States and the Empire of Japan. Germany then declared war against us and we were joined in global conflict. (It was fitting that we engaged both major foes. The Japanese were fed military information by a failed Nazi physician, Dr. Bernard Kuehn, and his family, who had been translocated to Oahu for that espionage.)

The lines at the enlistment stations on Monday morning, December 8, 1941, stretched as far as the eye could see. Factories went into full production; we became the "arsenal of democracy." Entertainers either served in the armed forces or went on war bond tours. Women entered the factories and the military. Religious connotations were attached: "Praise the Lord and pass the ammunition"; "There are no atheists in foxholes." The isolationism of the America Firsters was replaced by Wendell Wilkie's, "One World." We knew we must prevail because right was on our side. We did.

Change has been continuous since then. World order is different. Our enemies now are our allies. Nations of paupers now have the highest prices on earth. Governments once considered invulnerable are toppling. Countries are falling apart. Society also has changed. Rosie the riveter became the prototype of today's working woman. America's love affair with the automobile produced exurbia and suburbia. The multigenerational family home with continual supervision of children was replaced by the split-level, two-parent wage earners, and restructured family life.

The 50th anniversary of Pearl Harbor finds the country at a moral crossroads. We have suffered increasingly the plight of the homeless, the excesses and greed of the yuppie 1980s, the escalating crimes of violence, the deterioration of our principal cities, the misfeasance and malfeasance of elected officials, and the basic refusal to accept responsibility for our actions. Fortunately, we can see the return of some of the spirit that swept the United States in 1941 and made us one—proud of America, proud of being American, and proud of our fellow Americans. As a superpower after World War II, fortunate to have a country untouched physically by the devastation of war and industry running in top gear, we were able to become the economic savior of much of the rest of the world. But our military posture, acting at times as policeman to the world, began to rend us. The Korean police action, with the United States bearing most of the weight of the United Nations'

effort, caused dissent. The Bay of Pigs fiasco was not a source of pride. The Vietnam War almost produced the final split. Actions in Grenada, Panama, and the Persian Gulf (in particular) may be reparative forces.

So let us remember Pearl Harbor. Let us mourn the dead and damaged. Let us decry the destruction. Let us hope that the carnage of that war never is repeated. Let us celebrate the dedication and courage of those that served. And let us resolve to pattern our behavior after those who believed Americans to be people of diverse origins and backgrounds working together for the common good. Ethnicity is important; unity is essential.

> *"In peace the sons bury their fathers and in war the fathers bury their sons."* Sir Francis Bacon, *Apothegms,* 1624

Shooting Hoops. On a lighter note, we should celebrate another anniversary of some significance, the centennial of basketball. Dr. James A. Naismith, physician administrator at the YMCA in Springfield, Massachusetts, nailed up two peach baskets in December 1891, to be used with a soccer ball as an evening and winter sport. The game spread to other YMCAs in the Northeast, then to high schools and to colleges. Finally, basketball went to play-for-pay and the first professional team was founded in Trenton by the Cooper brothers, the first game being played on July 30, 1895. Al Cooper and Harry Stout were the starting forwards, Gus Endebrock was the center, and Billy Harrison and George Cartlidge (the captain) were the guards. Fred Cooper was a player and informal coach. Albert Bratton, Albert Mellick, Chris Stringer, Jimmy Hamilton, and Walter Cartlidge comprised the rest of the team. In their first year, they won 18 games and lost 2 games.

Trenton, Philadelphia, Camden, Wilmington, and Millville were founding teams of the league, begun in 1898; that area was the cradle of professional basketball for the first 10 to 15 years, with later expansion to New York, western Pennsylvania, and Massachusetts. In its early years the league cities were joined by rail and by water, roads being primitive and untrustworthy, and the players needing the financial support of their regular jobs. Today the game is enjoyed worldwide, but New Jersey has the grandest history of all.

> *"You can keep shooting and shooting and never be shot on a basketball court."* Anon

Thank you. Turkey day has come and gone, but it still is the season for giving thanks to the members of the Committee on Publication, the Editorial Board, the staff of MSNJ, especially Gerri and Nancy, reviewers and referees, all you busy people who have submitted manuscripts and letters to our tender mercies, and our readers—thank you one and all for your patience, contributions, and forbearance. Special thanks to William Himmelman of Sports Nostalgia Research in Norwood, historian to the National Basketball Association, who kindly furnished much of the basketball information.

Finally, if the bitter enemies that clashed 50 years ago and sowed mass destruction in the Pacific for the better part of four years now can meet fraternally, peacefully, and harmoniously at a concert in New Brunswick, there must be hope for us all.

Happy holidays and a healthy 1992. □ Howard D. Slobodien, MD

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Guest Editorial: What About Halcion®?

Daniel P. Greenfield, MD, MPH, MS

In this issue, Michael A. Nevins, MD, describes musical hallucinations, an unusual and interesting side effect of Halcion® (triazolam hydrochloride) in his patient (pages 907-908). Halcion®, a benzodiazepine hypnotic, is one of the most widely prescribed hypnotics in the world, and it probably has received more controversial—if not adverse—publicity than any other currently available psychotropic medication, with the possible exception of Prozac® (fluoxetine hydrochloride), an antidepressant. Halcion® recently was banned in Britain, for example, apparently because of such publicity, at least in part.

Musical hallucinations resulting from Halcion® are rare, but other side effects are not. Recognizing that, and recognizing the widespread prescribing of Halcion® and the benzodiazepines and the variety of questions and concerns associated with their use, I offer this editorial on Halcion® and the benzodiazepines in order to put the controversy into clinical perspective.

In 1988, Woods, Katz, and Winger published an article in the *Journal of the American Medical Association* that addressed the questions of indications for benzodiazepines, the possible overprescribing of benzodiazepines in this country, and, finally, the question of benzodiazepine dependence.[1] These issues and questions clearly are concerns to physicians who are faced with anxious, depressed, panicky, and sleepless patients, for whom benzodiazepines are indicated, at least on a limited-term basis. The desire to provide treatment for patients and relief of patients' symptoms is countered by concerns about addicting these patients to benzodiazepines, concerns that appear to be reinforced by the popular press and media, as well as by professional and quasiprofessional literature. In addressing these questions, the article by Woods is instructive; the article's general conclusions and recommendations are as follows: "The widespread use of benzodiazepines has been a source of concern and debate, due in large part to the traditional association of 'mood-altering' or sedating drugs with problems of abuse and dependence. Such problems have indeed been reported with the benzodiazepines, and the view has emerged that abuse and dependence might account for a substantial proportion of benzodiazepine use. On the other hand, many investigators have found that most benzodiazepine use is appropriate to the prevalence of the medical and psychiatric conditions for which they are deemed effective. Physicians prescribing these drugs are faced with the need to weigh the potential risk to their patients against the drugs' demonstrated benefit in the treatment of anxiety and insomnia."[1]

Thus, as with any class of medication, sensible, cautious, and careful prescribing of benzodiazepines, paying attention to indications for initiating, maintaining, and discontinuing treatment, is the prudent course. Prescribing guidelines for the benzodiazepines, including Halcion® are described elsewhere.[2]

What about Halcion®? For a variety of reasons, this hypnotic benzodiazepine has been scrutinized particularly carefully in the popular press and in the professional literature. Although this adverse publicity may well be affecting physicians' prescribing practices for this medication, the proper prescribing of Halcion® should be based on good science and good medicine. As a short-acting benzodiazepine, prescribed within prudent dose-response parameters, Halcion® can be effectively used on a short-term basis for patients with transient insomnia (generally not as a result of a primary sleep disorder), giving the appropriate dose ranges (paying particular attention to prescribing lower doses for elderly patients) and avoiding it—or any benzodiazepine—in patients known or suspected to abuse psychoactive substances (including alcohol), especially sedative-hypnotics. Like the other benzodiazepines, Halcion® is safe, having a toxicity profile similar to what would be expected of any short-acting sedative-hypnotic, with the same expected synergistic effects when taken with other sedative-hypnotics,

and also having such expectable side effects from short-acting sedative-hypnotics as rebound insomnia (with discontinuation of the medication), short-term memory disturbances, withdrawal agitation, and other symptoms.

SUMMARY

Although Halcion® has received a great deal of attention and scrutiny, Halcion® and the other benzodiazepines have a place in the pharmacotherapy of anxiety, panic, and sleep disturbances. Obviously, any physician's prescribing practices are going to be influenced by a variety of factors, including the popular press, to some extent. However, by paying careful attention to prudent and appropriate prescribing practices, following indications and guidelines for safety, efficacy, and patient acceptance, and by prescribing Halcion® with the same cautions one would prescribe any other short-acting benzodiazepine or other hypnotic, this medication can be safe, efficacious, and a useful adjunct to the treatment of insomnia. Side effects—even such rare ones as musical hallucinations—will occur, to a greater or lesser extent, as with any medication, but these can be managed by the prudent physician, taking into account the risk/benefit considerations of Halcion®, or any benzodiazepine, as a physician would in prescribing any medication for any reason. ■

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Dr. Greenfield is a member of the Editorial Board of *NEW JERSEY MEDICINE;* a managing partner in Brown and Greenfield, physician consultants in Millburn, New Jersey; and affiliated with the Department of Psychiatry at Albert Einstein College of Medicine/Montefiore Medical Center in the Bronx, New York.

Right foot, plantar surface of a 45-year-old male with diabetes.

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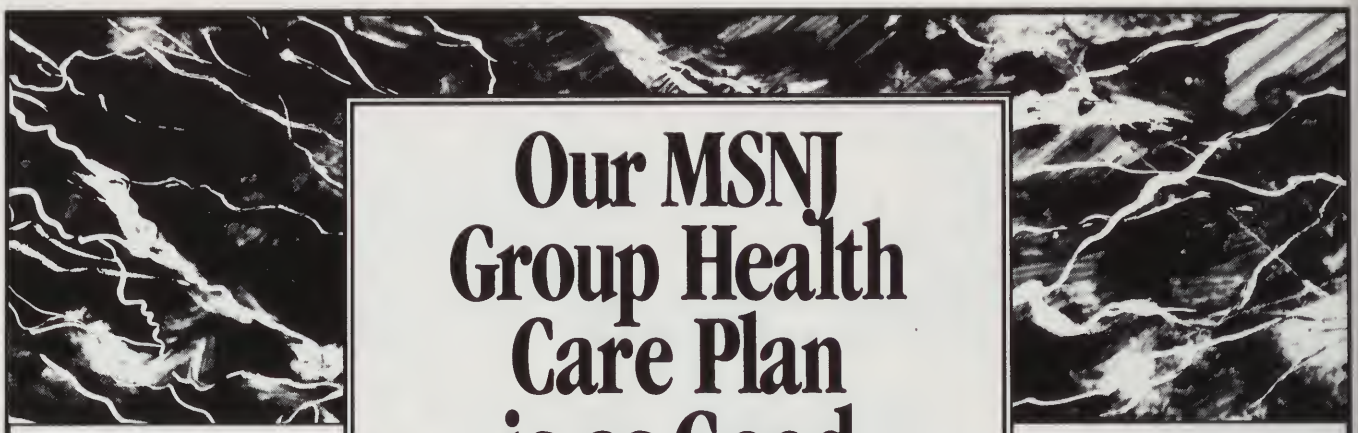
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PRESIDENT 'S PAGE

A TIME FOR COMING TOGETHER

On October 29 and 31, 1991, I was privileged to speak to the UMDNJ faculties of the New Jersey Medical School in Newark and the Robert Wood Johnson Medical School in Piscataway, respectively. Let me share my remarks with you:

I am especially proud to be here, because it is a rare occasion that the president of the Medical Society of New Jersey (MSNJ) speaks before the faculty of UMDNJ. This faculty is upbeat, confident, positive, and blessed with strong leadership traits. Of course, the goal of any medical school faculty and administration is to transform their students into well-educated physicians, who will practice medicine of high quality, with care and compassion, and who will visibly carry on the rich heritage of medicine. Teaching students the basic qualities to succeed, keeping them fresh and vigorous and up to date must be enormously satisfying. And all physicians and all of the people of this state are grateful to you for doing a tremendous job.

But, I am here today to tell you that it is not enough to teach students anatomy, physiology, and biochemistry, and later, in clinical years, family practice, internal medicine, surgery, and obstetrics/gynecology. Mastering those subjects will surely lead a student toward being a good physician—especially if we are not going to be able to practice medicine with inherent freedom and without outside overregulation and interference. Under the guise of "containing health care costs," the federal and state governments have placed so many restrictions on the practice of medicine that it will be difficult for the students



Joseph A. Riggs, MD

that you are now teaching to practice medicine, in the coming years, in the way we have been accustomed.

You see, my friends, today medicine is under fire. We see heat and smoke in federal efforts to reduce Medicare reimbursement by 16 percent or more. We see the signs of siege in state efforts to enact mandatory assignment, to require physicians to obtain certificates of need, and to suppress joint venturing and referrals. We, as health care professionals, now are being seen as agents of HIV infection who need to be tested and supervised. We seemingly cannot even be trusted to manage cases of Lyme disease without state oversight. Perhaps I should also mention: the rigors of the malpractice system, the efforts of the State Board of Medical Examiners to burden us with an overly extensive license renewal form, and the current exclusion of physicians from the state health policy boards to which you and I, in particular, could contribute great insights.

Next year, the development of a national health care system will be on the agenda as the main campaign issue in a presidential election. Unless we act effectively, it is possible that we won't have any friends among the candidates—only those who are against us and those who are not with us.

Students, under your guidance, will learn that it is prudent to become involved in student organizations, medical societies, and political action. Thus, they will not only be good physicians, but they also will be more complete physicians. Indeed, last year in this country there were over 300 health care related bills that were introduced, and many of them affect you and me and our students. Let's get rid of the myth right now that these bills are for private practitioners only. They also seriously affect you! Inadequate Medicare reimbursement and mandatory assignment will affect the income of practicing physicians. And you all know that medical school survival is more and more dependent on the faculty practice funds.

We, in the Medical Society, are fighting these battles to ensure quality health care for our patients. But you are underrepresented in these battles. Only 16 percent of faculty are members of MSNJ, and only 14 percent belong to the AMA.

There is only one way to battle this situation. All private practitioners, all faculty, all residents, and all students must stand united and organized. No one person can fight these governmental forces alone. But to-

gether we can!

And all of you know where unity in the profession of medicine in New Jersey begins. It originates with MSNJ. MSNJ is the organization that fully represents all physicians in our 21 counties. We have been—and will continue to be—successful in resisting some of the more burdensome intrusions that politicians and regulators have proposed.

At MSNJ, we are engaged in public relations campaigns. We support numerous public health initiatives—from environmental health, to a cancer center, to HIV testing, plus many other member benefits and services.

Together we can have a magnificent effect on how and what legislative leaders are thinking and doing. Thus, I am here to tell you that we need your input and we want you to become more involved. Join with us, MSNJ and AMA, as we approach the 21st century. As the flames grow, let's become more enlightened about the need and opportunities for unified action. Let's see this as a time of gathering.

I realize that for too many years organized medicine has ignored the interests of academic medicine, women physicians, international medical school graduates, and other physician groups, who were a little bit out of the mainstream. And in the meantime, the academic faculties have chosen to remain uninvolved.

Well, this adverse environment has to cease. This is the new MSNJ and the new AMA. Today, the medical community, the house of medicine, has to be increasingly united—and creative—and self-aware. For the past years that I have been intimately involved, I cannot remember one full time faculty member on the Board of Trustees of MSNJ and very few belong to the House of Delegates. At Jefferson Medical College in Philadelphia, where I am a professor in gynecology, 56 percent of the faculty belong to organized medicine.

You see, we no longer are truly separate from each other. I have heard that there exists another myth—that since many of you are not in private practice, you don't have to worry about medical decision making. Not so! You no longer can sit back and expect someone else to do all this fighting for you.

Finally, there is another reason why it is important for more academic physicians to join MSNJ. You are examples to your students and residents. Your participation will help show future practitioners that involvement in our Society is part of being a complete physician—part of belonging to the house of medicine.

You—the faculty of UMDNJ—are guiding students toward a bright and fulfilling future—and the keys to that future lie in your hands. You are teaching them the basic qualities needed to succeed, but you also have to be a shining example for them. You are very special and privileged persons who have the opportunity to set the foundation for the future physicians of America. Please join us to help these students become more complete physicians. If you do so, you will honor not only our profession, but also this institution and this state. Seize the moment and get involved so that the future remains bright with promise. Let me ask you now to give a call to your county medical society. Take the initiative in practicing unity and harmony in our profession.

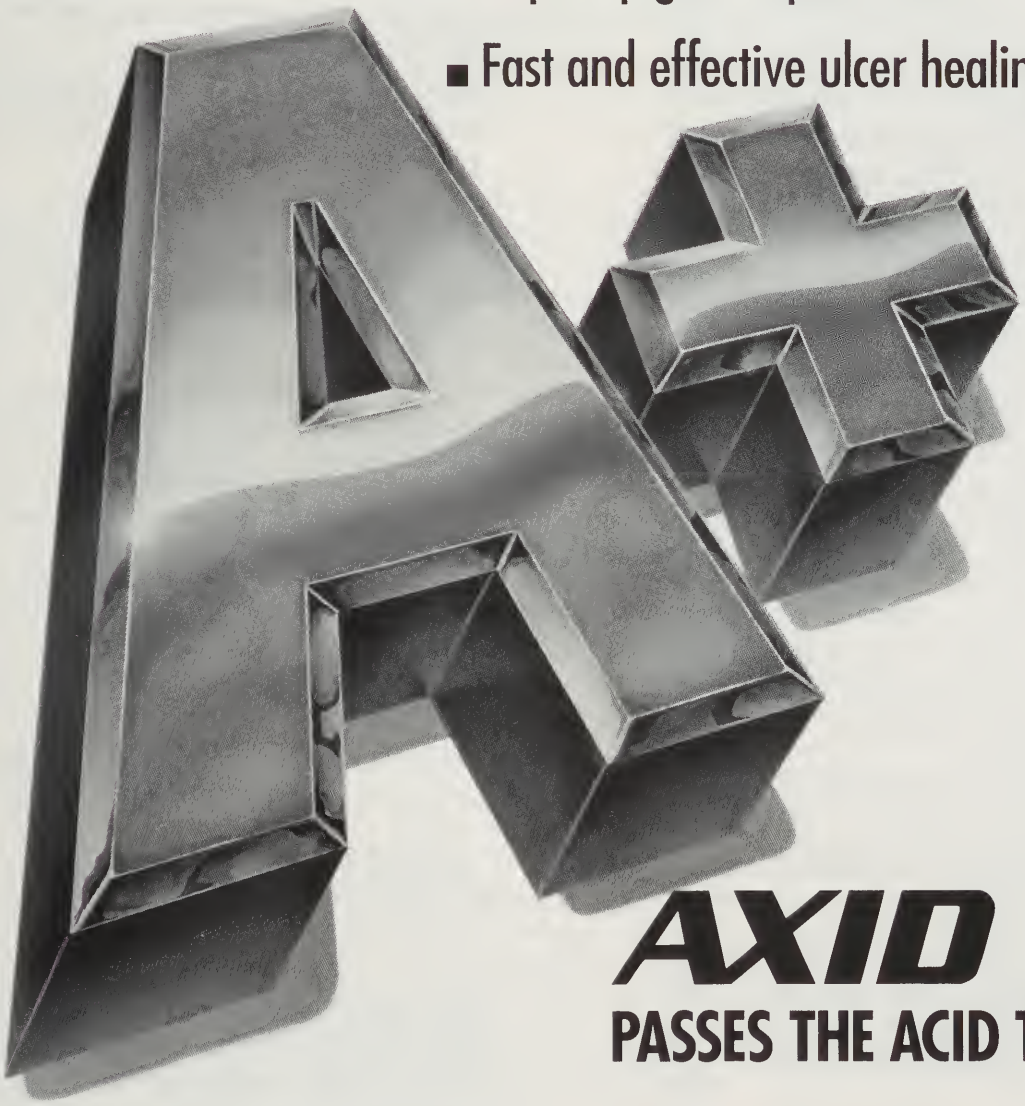
I look forward to meeting with you and hearing your news as members of the new MSNJ and the new AMA during the coming years. Thank you for allowing me the privilege of speaking to you today. God bless! □ Joseph A. Riggs, MD

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See adjacent page for references and brief summary of prescribing information.

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Brief Summary. Consult the package insert for complete prescribing information.
Indications and Usage: 1. *Active duodenal ulcer* – for up to 8 weeks of treatment. Most patients heal within 4 weeks.

2. *Maintenance therapy* – for healed duodenal ulcer patients at a reduced dosage of 150 mg h.s. The consequences of therapy with Axid for longer than 1 year are not known.

Contraindications: Known hypersensitivity to the drug. Because cross sensitivity in this class of compounds has been observed, H_2-receptor antagonists, including Axid, should not be administered to patients with a history of hypersensitivity to other H_2-receptor antagonists.

Precautions: *General* – 1. Symptomatic response to nizatidine therapy does not preclude the presence of gastric malignancy.

2. Dosage should be reduced in patients with moderate to severe renal insufficiency.

3. In patients with normal renal function and uncomplicated hepatic dysfunction, the disposition of nizatidine is similar to that in normal subjects.

Laboratory Tests – False-positive tests for urobilinogen with Multistix® may occur during therapy.

Drug Interactions – No interactions have been observed with theophylline, chlordiazepoxide, lorazepam, lidocaine, phenytoin, and warfarin. Axid does not inhibit the cytochrome P-450 enzyme system; therefore, drug interactions mediated by inhibition of hepatic metabolism are not expected to occur. In patients given very high doses (3,900 mg) of aspirin daily, increased serum salicylate levels were seen when nizatidine, 150 mg b.i.d., was administered concurrently.

Carcinogenesis, Mutagenesis, Impairment of Fertility – A 2-year oral carcinogenicity study in rats with doses as high as 500 mg/kg/day (about 80 times the recommended daily therapeutic dose) showed no evidence of a carcinogenic effect. There was a dose-related increase in the density of enterochromaffin-like (ECL) cells in the gastric oxyntic mucosa. In a 2-year study in mice, there was no evidence of a carcinogenic effect in male mice, although hyperplastic nodules of the liver were increased in the high-dose males as compared with placebo. Female mice given the high dose of Axid (2,000 mg/kg/day, about 330 times the human dose) showed marginally statistically significant increases in hepatic carcinoma and hepatic nodular hyperplasia with no numerical increase seen in any of the other dose groups. The rate of hepatic carcinoma in the high-dose animals was within the historical control limits seen for the strain of mice used. The female mice were given a dose larger than the maximum tolerated dose, as indicated by excessive (30%) weight decrement as compared with concurrent controls and evidence of mild liver injury (transaminase elevations). The occurrence of a marginal finding at high dose only in animals given an excessive and somewhat hepatotoxic dose, with no evidence of a carcinogenic effect in rats, male mice, and female mice (given up to 360 mg/kg/day, about 60 times the human dose), and a negative mutagenicity battery are not considered evidence of a carcinogenic potential for Axid.

Axid was not mutagenic in a battery of tests performed to evaluate its potential genetic toxicity, including bacterial mutation tests, unscheduled DNA synthesis, sister chromatid exchange, mouse lymphoma assay, chromosome aberration tests, and a micronucleus test.

In a 2-generation, perinatal and postnatal fertility study in rats, doses of nizatidine up to 650 mg/kg/day produced no adverse effects on the reproductive performance of parental animals or their progeny.

Pregnancy – Teratogenic Effects – Pregnancy Category C – Oral reproduction studies in rats at doses up to 300 times the human dose and in Dutch Belted rabbits at doses up to 55 times the human dose revealed no evidence of impaired fertility or teratogenic effect; but, at a dose equivalent to 300 times the human dose, treated rabbits had abortions, decreased number of live fetuses, and depressed fetal weights. On intravenous administration to pregnant New Zealand White rabbits, nizatidine at 20 mg/kg produced cardiac enlargement, coarctation of the aortic arch, and cutaneous edema in 1 fetus, and at 50 mg/kg, it produced ventricular anomaly, distended abdomen, spina bifida, hydrocephaly, and enlarged heart in 1 fetus. There are, however, no adequate and well-controlled studies in pregnant women. It is also not known whether nizatidine can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Nizatidine should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers – Studies in lactating women have shown that 0.1% of an oral dose is secreted in human milk in proportion to plasma concentrations. Because of growth depression in pups reared by treated lactating rats, a decision should be made whether to discontinue nursing or the drug, taking into account the importance of the drug to the mother.

Pediatric Use – Safety and effectiveness in children have not been established.

Use in Elderly Patients – Healing rates in elderly patients were similar to those in younger age groups as were the rates of adverse events and laboratory test abnormalities. Age alone may not be an important factor in the disposition of nizatidine. Elderly patients may have reduced renal function.

Adverse Reactions: Clinical trials of varying durations included almost 5,000 patients. Among the more common adverse events in domestic placebo-controlled trials of over 1,900 nizatidine patients and over 1,300 on placebo, sweating (1% vs 0.2%), urticaria (0.5% vs <0.01%), and somnolence (2.4% vs 1.3%) were significantly more common with nizatidine. It was not possible to determine whether a variety of less common events were due to the drug.

Hepatic – Hepatocellular injury (elevated liver enzyme tests or alkaline phosphatase) possibly or probably related to nizatidine occurred in some patients. In some cases, there was marked elevation (>500 IU/L) in SGOT or SGPT and, in a single instance, SGPT was >2,000 IU/L. The incidence of elevated liver enzymes overall and elevations of up to 3 times the upper limit of normal, however, did not significantly differ from that in placebo patients. All abnormalities were reversible after discontinuation of Axid. Since market introduction, hepatitis and jaundice have been reported. Rare cases of cholestatic or mixed hepatocellular and cholestatic injury with jaundice have been reported with reversal of the abnormalities after discontinuation of Axid.

Cardiovascular – In clinical pharmacology studies, short episodes of asymptomatic ventricular tachycardia occurred in 2 individuals administered Axid and in 3 untreated subjects.

CNS – Rare cases of reversible mental confusion have been reported.

Endocrine – Clinical pharmacology studies and controlled clinical trials showed no evidence of antiandrogenic activity due to nizatidine. Impotence and decreased libido were reported with equal frequency by patients on nizatidine and those on placebo. Gynecomastia has been reported rarely.

Hematologic – Fatal thrombocytopenia was reported in a patient treated with nizatidine and another H_2-receptor antagonist. This patient had previously experienced thrombocytopenia while taking other drugs. Rare cases of thrombocytopenic purpura have been reported.

Integumental – Sweating and urticaria were reported significantly more frequently in nizatidine- than in placebo-treated patients. Rash and exfoliative dermatitis were also reported.

Hypersensitivity – As with other H_2-receptor antagonists, rare cases of anaphylaxis following nizatidine administration have been reported. Rare episodes of hypersensitivity reactions (eg, bronchospasm, laryngeal edema, rash, and eosinophilia) have been reported.

Other – Hyperuricemia unassociated with gout or nephrolithiasis was reported. Eosinophilia, fever, and nausea related to nizatidine have been reported.

Overdosage: Overdoses of Axid have been reported rarely. If overdosage occurs, activated charcoal, emesis, or lavage should be considered along with clinical monitoring and supportive therapy. Renal dialysis does not substantially increase clearance of nizatidine due to its large volume of distribution.

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2. *Scand J Gastroenterol* 1987;22(suppl 136):61-70.
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Advance Directives for Health Care: Clinical Implications

Robert L. Pickens, MD
Alan J. Lippman, MD

With the passage of new legislation concerning living wills, or advance directives for health care, the MSNJ Committee on Biomedical Ethics offers its resources to the physicians of the state including distribution of educational material and provision of sample advance directive forms.

Two new laws—the federally mandated Patient Self-Determination Act (PSDA) and the New Jersey Advance Directives for Health Care Act (NJADHCA)—have caused physicians to direct attention to the important matter of living wills, or advance directives for health care. These laws, each complementing the other, place significant obligations on health care institutions and health care providers.

PSDA, as part of the Omnibus Budget Reconciliation Act of 1990, took effect December 1, 1991.[1] This law requires that hospitals and other health care agencies, including long-term facilities, hospices, and health maintenance organizations, advise patients, on admission, of their right under state law to accept or refuse medical care and to execute advance directives. Compliance with this Act is a condition for Medicare and Medicaid reimbursement.

Signed into law by Governor Jim Florio on July 11, 1991, NJADHCA assures the state's citizens of their legal right to plan ahead for critical health care decisions.[2] This law, which becomes effective January 7, 1992, acknowledges that whereas modern medical technology makes possible prolongation of life for many seriously ill individuals, it does not always offer realistic prospects for improvement or cure.

In such circumstances, it is the purpose of this law to protect and preserve the right of patients to participate in health care decisions in which life-prolonging procedures may be provided, withheld, or withdrawn. The law provides that patients may exercise advance directives and appoint a proxy, otherwise known as a health care representative, to act on their behalf if they have lost decision-making capacity.

BACKGROUND

The first living will legislation, known as the Natural Death Act, was enacted in California in 1976. This came in the wake of the New Jersey Supreme Court's ruling in the matter of Karen Ann Quinlan[3] and was intended to forestall similar litigation in that state by legitimatizing advance directives and, thereby, imparting greater certainty to the decision-making process for incompetent patients. Since that time, 47 states and the District of Columbia have enacted living will statutes; New Jersey is the most recent state to pass this legislation.

An advance directive for health care is a document providing instructions indicating what kind of medical care an individual might want in the event of incapacity or inability to make such wishes known at some later time. The form taken by an advance directive may vary—it could be a written document, a set of transcribed verbal instructions, or a videotaped documentary—but it should contain a clear description of the specific interventions to be permitted and, particularly, those to be avoided. In addition, such a directive may provide for the appointment of a health care representative, a proxy for health care decision making.

Contrary to protests by right-to-life advocates, the living will is not a right-to-die document; it is a right-to-choose document. A living will document is not a dry, static piece of paper meant to impede decision making or to compromise the major role that physicians play in health care decision making. It is a living document, one that can be further strengthened by the appointment of a health care representative. It is a communication tool meant to stimulate discussion among patient, family, and physician about health care wishes prior to incapacity. It is meant to express one's perspective about death and one's personally held values regarding illness.

The living will is a covenant that promotes the ethical model of shared decision making, where health care professionals have an obligation to assist competent patients, before they may become incompetent, to understand treatment options in the event of debilitating or terminal illness. Shared decision making promotes trust within the physician-patient relationship. It recognizes that, within the patient-physician-family triad, each brings to the relationship special insight that the other lacks. The physician brings medical knowledge and skills as well as a set of professional values and goals. The patient and family bring knowledge of personal values and goals that are necessary to weigh the risks and benefits of treatment.

Shared decision making has placed a new burden on the physician. Schooling, residency training, and professional oath emphasize positive actions to sustain and prolong life. A physician does not easily accept the concept that it may be best to do less, rather than more. The decision to pull back is much more difficult than the decision to push ahead with aggressive therapy. Today's sophisticated medical technology invites a physician to make use of all means at his disposal. In addition, the uncertainty of diagnosis and prognosis often makes it difficult to predict the length and quality of a patient's life with or without treatment. Fear of malpractice liability may interfere with the physician's ability to make the best choice for the patient.

The entire question of whether, and under what circumstances, a patient may refuse life-sustaining medical treatment came to national and international attention in 1976, with the New Jersey Supreme Court's decision in the case of Karen Ann Quinlan.[3] In the Quinlan case, the court held that a patient has a fundamental right to refuse life-sustaining treatment, grounded in the right of privacy under federal and state constitutions. The court further held that a patient does not lose the right to refuse treatment in the event of incompetency, and that this right may be exercised by another on the patient's behalf. In this regard, the court appointed Karen's father as legal guardian with the authority to exercise this right on his daughter's behalf. The Quinlan ruling subsequently was reinforced by New Jersey Supreme Court rulings in the Conroy case and the Peter, Jobes, and Farrell cases. As summarized in the Peter decision, "All patients, competent or incompetent, with some limited cognitive ability or in a persistent vegetative state, terminally ill or not terminally ill, are entitled to choose whether or not they want life-sustaining medical treatment."

The context in which to view a living will, or advance directive, revolves around a patient's right to make informed decisions about his medical treatment. It is grounded in the common law right of self-determination and the constitutional right of privacy, supported by a Presidential commission, in a 1983 report. Whether grounded in common law or constitutional law, courts have uniformly recognized the right to refuse life-sustaining treatment as a fundamental tenet of respect for patient autonomy and self-determination. It is the law of informed consent that requires a physician to obtain consent from a patient prior to performing treatment, with the logical corollary that the patient may refuse consent to treatment.

What, then, is an advance directive? It is an anticipatory document, based on contingent decision making, whereas a classical informed consent is more immediate or contemporaneous, with decisions being made about a current treatment. An advance directive serves two purposes: It is a way in which an individual may exercise some degree of control over medical care, in case he lacks the capacity to do so at a future time when a decision must be made. It is the best evidence of a patient's wishes. Secondly, an advance directive helps to avoid confusion about how decision making should proceed and can forestall the need for judicial review. Proxy designation allows the patient to appoint a surrogate and obviates the need for judicial review or appointment of a guardian.

If an advance directive is to be useful, it must strike a balance between being too specific and too general. It should avoid specificity that fails to cover a contingency that may have been unpredictable. It should not be so broad that it is unclear what decision the declarant would make. It is impossible for an individual to specify with precision all the events that might arise and what sort of treatments he would or would not want if these conditions were to materialize. The appointment of a health care representative to speak for the patient may overcome these shortcomings.

Despite the existence of natural death acts in many states, living wills have uncommonly been executed by individuals. It is estimated that fewer than 10 percent of all individuals in states where living will legislation has been enacted actually have completed a living will. Recently, however, two events have spurred renewed interest in living wills. The first was the Supreme Court's decision in the case of Nancy Cruzan.[4] The family of Nancy Cruzan had petitioned the Missouri courts to allow them to remove an artificial feeding tube from their daughter, who had been in an irreversible coma for more than seven years. The Missouri courts claimed that there was no "clear and convincing evidence" that Ms. Cruzan would want the tube removed and asserted their interest in protecting life and guarding incompetent patients against possible abuse. The case was taken to the United States Supreme Court, which up-

held Missouri's requirement of "clear and convincing" evidence in order for the feeding tube to be removed. At the same time, however, the court found that people who make their wishes clearly known, either because they currently are able to express them or because they expressed themselves clearly before they became incompetent, have a "liberty interest in being free of unwanted medical care." Eight justices endorsed this interpretation of the constitution's due process guarantee. Subsequent to the Cruzan ruling, the New Jersey Bioethics Commission, the Citizens' Committee on Biomedical Ethics, Inc., the Society for the Right To Die, and Concern for Dying received tens of thousands of calls requesting information about living wills and advance directives so that patients could make their wishes known in a "clear and convincing" way "prior to becoming disabled and lacking decision-making capacity."

REQUIREMENTS OF PSDA

Congress passed PSDA in November 1990; it requires health care facilities to do the following:

1. Maintain written policies and procedures concerning an individual's right to make decisions concerning care, including the right to accept or refuse medical or surgical treatment and the right to formulate an advance directive.

2. Provide written information to all individuals at the time of admission concerning individual rights under state law to make decisions regarding medical care and the facility's policies regarding the implementation of such rights.

3. Inquire of individuals seeking admission whether or not they have written advance directives.

4. Document in each individual's medical record whether or not the individual has executed an advance directive.

5. Ensure compliance with advance directives consistent with state law.

6. Provide education regarding advance directives for the staff and the community.

Health care institutions may not condition the provision of care or otherwise discriminate against an individual based on whether or not the individual has executed an advance directive. Furthermore, there is no intention to prohibit the application of a state law that may allow for an objection on the basis of conscience for any health care provider which, as a matter of conscience, chooses not to implement an advance directive.

The law does not require individuals to complete advance directives. It does require that all individuals receiving medical care be given written information about their rights under state law to make decisions about care. They also must be given information about their right to formulate advance directives. Institutions must prepare policies consistent with state law that allow individuals to exercise these rights and will be responsible for documenting in medical records whether an advance directive has been executed.

ADVANCE DIRECTIVES

NJADHCA puts into statutory law what already has been decided by case law in the state of New Jersey. In addition, it expands the circumstances under which a living will can direct care and treatment. Under this act, advance directives can designate both an "instruction directive," a statement of personal wishes regarding health care in the event of loss of decision-making capacity, and a "proxy directive" in which another person, friend, relative, or loved one, is appointed to act in good faith to make health care decisions on behalf of the incapacitated patient.

The Act defines those circumstances under which life-sustaining treatment may be withheld or withdrawn, to include:

1. A patient with a terminal condition, as determined by the attending physician and confirmed by a second qualified physician.

2. A patient who is permanently unconscious, as determined by the attending physician and confirmed by a second physician.

3. A patient with a serious, irreversible illness or condition in which the risks and burdens of medical intervention outweigh the benefits, or medical intervention would be inhumane.

4. Experimental, unproved treatment likely to be ineffective or futile.

Notwithstanding these four points, NJADHCA may not be construed as granting authorization to withhold or withdraw life-support measures in the absence of explicit instructions to that effect in the patient's advance directive. In fact, NJADHCA goes beyond this in clearly stating an express rejection of the practice of active euthanasia.

NJADHCA confers specific obligations upon physicians and health care institutions. In the case of physicians:

1. The attending physician shall make an affirmative inquiry of the patient, or, as appropriate, of the health care representative, of the existence of an advance directive. Any existing advance directive is to be attached to the patient's medical record.

2. The attending physician has the responsibility to determine the capacity of the patient to make health care decisions. If the physician deems that the patient lacks such capacity, this shall be confirmed by one or more other physicians and these opinions are to be stated in writing in the patient's medical record.

3. If the physician determines that a patient lacks decision-making capacity as a result of mental or psychological impairment or a developmental disability, and the physician lacks specialized training in such areas, then a confirmatory determination shall be made by another physician duly trained or experienced.

Physicians and other health care professionals may decline to withhold or withdraw life-sustaining measures, in accordance with their personal or professional convictions. In such cases, the patient or health care representative is to be informed accordingly and care of the patient shall be transferred in a timely and respectful manner to another designated caregiver.

Obligations and responsibilities of health care facilities under NJADHCA are similar to those required in PSDA. These include:

1. The health care institution shall adopt such policies and practices as are necessary to provide for inquiry, at the time of admission, concerning the existence and location of an advance directive.

2. The health care institution shall provide appropriate informational materials concerning advance directives to all interested patients and their families and health care representatives, and provide assistance in executing advance directives, as appropriate.

3. The institution shall assure that the patient or health care representative is provided the opportunity to be part of the decision-making process regarding health care options.

4. The institution is obliged to establish procedures and practices for dispute resolution. This is usually taken to mean the mechanism of a bioethics committee convened for this purpose.

An important aspect of the New Jersey Act is the provision that emergency personnel, e.g. firefighters, paramedics, ambulance personnel, rescue workers, and emergency room personnel, are not required to withhold emergency care in circumstances that would not afford a reasonable opportunity for careful review and evaluation of an advance directive without endangering the life of a patient.

IMPLICATIONS

What are the implications for medical practitioners with respect to the implementation of these laws?

A physician is likely to be called upon to provide advice and counsel to patients and health care representatives regarding advance directives. Patients will be somewhat knowledgeable with regard to these matters and as these laws are implemented, patients may tend to be confused and ambivalent. They naturally will approach the physician for clarification and reassurance and the physician will need to be in a position to provide meaningful and useful information to enable patients and families to understand the purpose and meaning of the legislation. Health care personnel, including nurses, social workers, and clergy also will need to be knowledgeable and be willing to spend time and effort toward the educative process.

What has been done to familiarize all parties with the content of the legislation and the implication so represented?

The New Jersey Commission on Legal and Ethical Problems in the Delivery of Health Care and its Task Force on Public and Professional Education has issued a booklet designed to help individuals complete advance directives.[5] The brochure contains an explanation of the legislation and the purpose of advance directives and how such directives enable meaningful participation in health care decisions. Relevant terms are defined and common questions answered. Representative forms are provided, including proxy directives and instruction directives.

The Committee on Biomedical Ethics of the Medical Society of New Jersey has offered its resources to physicians through individual county medical societies, including distribution of educational material and provision of sample advance directive forms. Individual health care facilities are charged with the responsibility to provide educational opportunities, including teaching conferences and written material.

Although the provisions of the new laws may seem complicated, the process need not be burdensome. Physicians commonly and routinely involve patients and families in health care decisions, and the principles of informed consent and the right of self-determination are cornerstones of ethical medical care. The challenge is to regard the process as a means of fostering communication between a doctor and a patient, as well as respect for the patient's autonomy.[6,7] ■

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Drs. Pickens and Lippman wrote this article on behalf of the Committee on Biomedical Ethics of the Medical Society of New Jersey.



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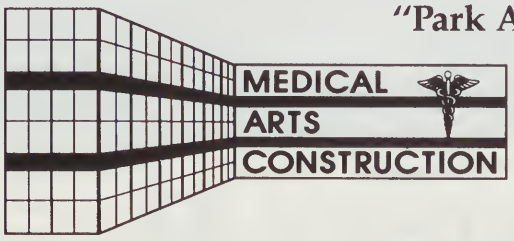
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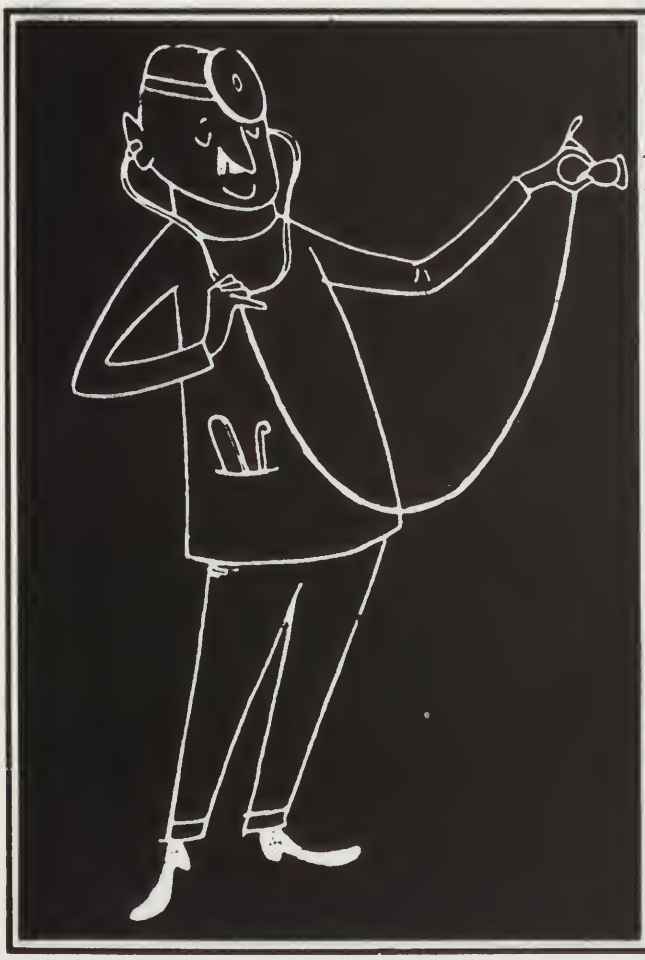
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Oncogene Probes in the Diagnosis of Malignant Lymphoma

Kumudini U. Mehta, MD
Robert Benedetti, MD

The authors discuss the utility of oncogene probes to differentiate a case of follicular non-Hodgkin's lymphoma from follicular lymphoid hyperplasia. The case report concerns a 50-year-old white male; physical examination revealed generalized, marked lymphadenopathy.

Most non-Hodgkin's lymphomas have characteristic chromosomal abnormalities. Translocation or deletion of a chromosome segment represents oncogene deregulation or loss of critical DNA sequences, respectively. The chromosomal alterations observed in malignant lymphomas are believed to foster tumor evolution, diversity, and aggressiveness.[1]

Approximately 85 percent of follicular lymphomas display translocations involving chromosomes 14 and 18. In these cases, chromosomal translocations result such that the bcl-2 (B cell lymphoma 2) gene, on chromosome 18, becomes closely apposed to the immunoglobulin heavy chain locus on chromosome 14.[2-6] This proto-oncogene has been implicated in the pathogenesis of follicular lymphoma.[7]

In routine surgical pathology, follicular malignant lymphoma often is difficult to distinguish from follicular hyperplasia. With new molecular techniques such as Southern blot analysis, monoclonality for the immunoglobulin gene can be identified with the use of heavy chain (JH) and light chain J (kappa) and J (lambda) DNA probes. This case report will document the use of the bcl-2 probe to further confirm the diagnosis of malignancy.

CASE REPORT

We examined a 50-year-old white male with an ill-defined indurated mass on anterior one-third of the tongue and on the floor of his mouth that progressively enlarged and became painful over a four-month period. He smoked for 45 pack-years and had been a heavy drinker. Physical examination revealed generalized, marked lymphadenopathy that the patient stated had been present for nearly 3 years. The HIV antibody was negative. Chest and abdominal scans disclosed superior mediastinal and retroperitoneal lymphadenopathy. Excisional biopsies of cervical and axillary nodes and tongue mass were performed.

MATERIALS AND METHODS

Histological methods: Five μ sections were prepared from the formalin-fixed paraffin embedded lymph nodes and tongue biopsies and stained with hematoxylin and eosin.

Southern blot analysis: High molecular weight deoxyribonu-

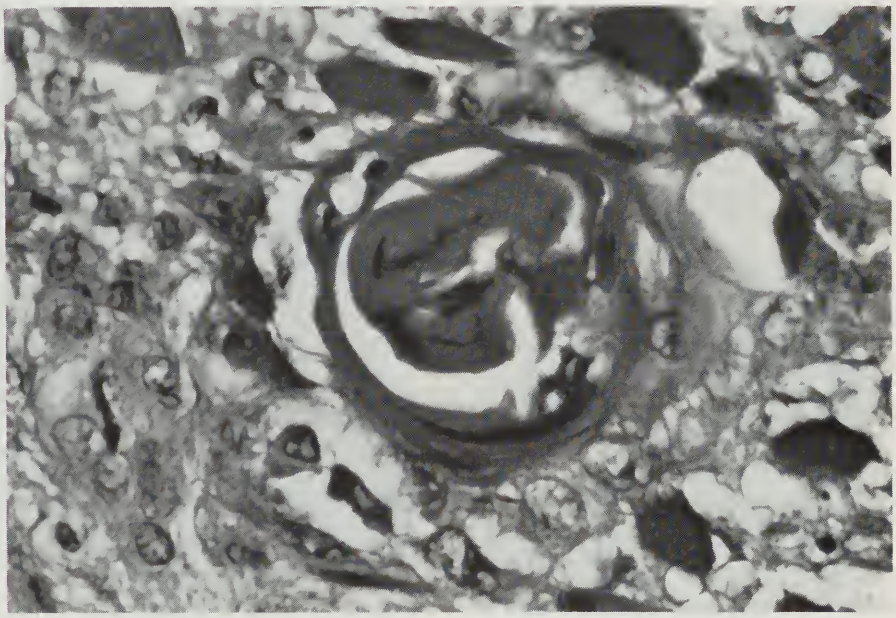


Figure 1. Squamous cell carcinoma on the floor of the mouth (hematoxylin and eosin stain, original magnification x 400).

cleic acid (DNA) was prepared from frozen lymph nodes by using DNA extraction reagents. The DNA was digested with EcoRI, HindIII, BamHI, and PstI restriction enzymes and electrophoresed on 0.8 percent agarose gels. After denaturation and neutralization, the DNA was transferred to nitrocellulose paper by Southern's technique. Hybridization with ^{32}P labeled JH and bcl-2 DNA probes were performed at 45°C in solutions of hybridization reagents, and then those filters were washed in a solution of 0.1 X saline sodium citrate and 0.1 percent sodium deodecyl sulfate at 52°C for one hour. The washed filters then were subjected to autoradiography for one to three days at –70°C with two intensifying screens.

PATHOLOGY FINDINGS

The tumor on the floor of the mouth was a well-differentiated, keratinizing squamous cell carcinoma characterized by squamous pearls (Figure 1). In contrast, the lymph nodes exhibited a separate lesion. The normal architecture was obliterated and replaced by numerous, variable-sized lymphoid nodules composed of small cleaved lymphocytes (Figure 2). While the condition resembled follicular hyperplasia on frozen section, its malignant nature was clear from application of DNA probes. The nodal tissue showed monoclonality for the heavy chain immunoglobulin gene (Figure 3) and was positive for bcl-2 rearrangement (Figure 4).

COMMENTS

Molecular technology provides an important tool for the study of various human neoplasms. Firm evidence has been accumulating that human cancer arises from derangement of genes. Some genes, the proto-oncogenes, are normal cellular genes that play a critical role in growth and differentiation.[8] Examples include bcl-2, c-myc, scr, abl, erb-B2, H ras, k-ras, N-ras, and cis. The proto-on-

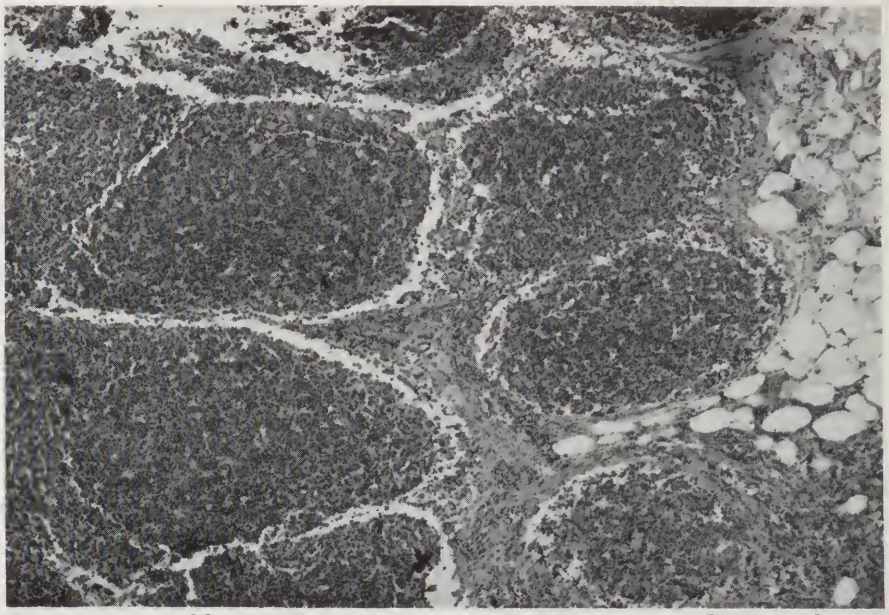


Figure 2. Variable-sized lymphoid nodules in a lymph node (hematoxylin and eosin stain, original magnification X 175).

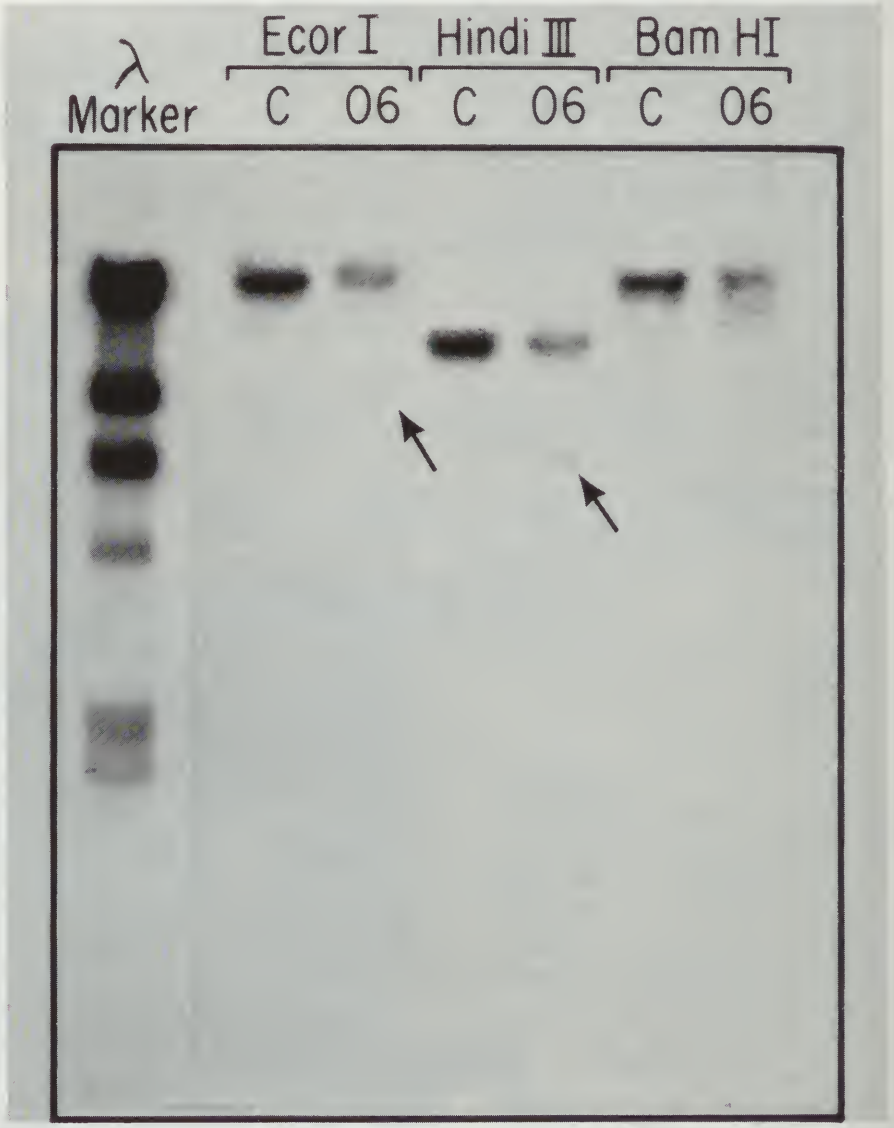


Figure 3. Southern blot analyses of lymph node. Note the nodal tissue in lane 2, (labeled 06). Placental DNA serves as the control (lane 1, labeled C). EroRI and HindIII digestion and subsequent hybridization with JH probe disclose heavy chain gene rearrangement (arrow).

cogenes are converted to oncogenes, which are involved in the development of neoplastic process by any of several mechanisms, including: point mutation, translocation, and amplification. Proto-oncogenes, important in the pathogenesis of maligant lymphomas, are bcl-2 and c-myc. Translocation appears to be the mechanism by which these genes convert to oncogenes. For example, c-myc, normally located on chromosome 8, translocates to chromosome 14 closer to the strong promoter/enhancer heavy chain gene; it actively transcribes heavy chain immunoglobulin. The result is a monoclonal neoplastic proliferation of B cells and formation of Burkitt's lymphoma.[9]

A second such putative proto-oncogene is bcl-2 (B cell lymphoma 2), located on chromosome 18q21. It frequently is rearranged in low-grade follicular lymphoma and exhibits a characteristic translocation, t(18;14). Patients with this translocation have an indolent disease that induces a picture of a premalignant follicular lymph node or a frank malignant lymphoma. Most patients do not require treatment during the first few years after diagnosis.[1]

CONCLUSION

This case report exemplifies the use of molecular studies to further refine diagnostic capabilities, especially in clinical circumstances where the differential diagnosis is reactive lymphadenopathy versus lymphoma. ■

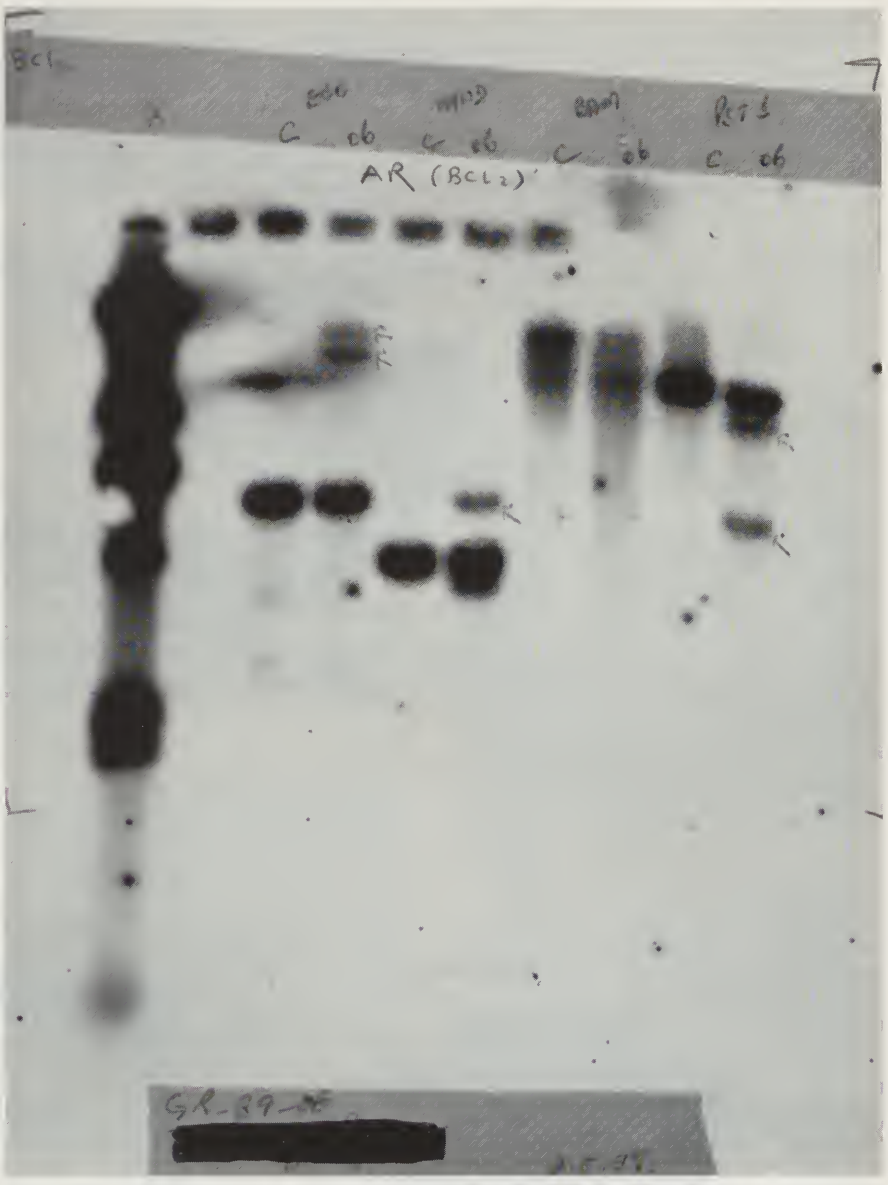


Figure 4. Bcl-2 gene rearrangement (arrow).

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Musical Hallucinations and Triazolam Use

Michael A. Nevins, MD

Musical hallucinations developed in a healthy 57-year-old man after using hypnotic triazolam (Halcion®) for eight nights; the hallucinations continued for over one year. Although a causal relationship to triazolam cannot be proved, use of this drug has been associated with other bizarre alterations of memory.

Published accounts of musical hallucinations are uncommon. Recent reviews have detected fewer than 50 cases in the medical literature, mostly in patients who either had coexisting major psychiatric illness, hearing loss, brain tumor, or temporal lobe epilepsy.[1,2] The following account describes the phenomenon in a middle-aged man who had none of the conventional causes, but whose symptoms began coincident to withdrawal from the hypnotic triazolam.

CASE REPORT

A 57-year-old man complained of repetitive musical hallucinations that began when he stopped taking .25 mg/day of triazolam (Halcion®) after eight consecutive nights of use. In the past, he had used the drug because of insomnia, but never for more than two or three nights at a time. On occasion, he had observed that triazolam was "not just a sleeping pill," but sometimes, on the day after its use, he had a heightened sense of well-being or euphoria. The present use spanned the last six nights of a business trip to his native Italy and continued for the first two nights after return to this country. The onset of symptoms occurred on the first night that he did not use the hypnotic and on the same evening that he had a prolonged argument. On the return flight, he had two champagne cocktails and several glasses of wine; ordinarily, he did not use alcohol excessively. There were no visual hallucinations, no related neurologic symptoms, and no behavior or memory disturbances. When the hallucinations persisted for a week, he sought medical attention.

The patient was in good health and had no history of psychiatric illness or hearing disturbance. His only other medication was Enlapril® that he had used for more than a year because of mild hypertension. The family history was noteworthy in that his father had died at the age of 23 in Sicily of "cancer of the trigeminal" and a paternal uncle was said to have suffered from "severe epilepsy."

Initially, the repetitive hallucinations consisted of lyrics and tunes of 15 or 20 familiar Italian songs, none of which had any particular significance for him and did not provoke emotion or nostalgia. The hallucinations were not necessarily songs from his past. Although he was able to alter the songs by consciously thinking of another melody, comparable to changing a cassette tape or radio station, the new song then would continue on monotonously. The sounds often lasted for hours and could be masked if he concentrated or was intellectually absorbed, but would return as soon as his attention waned.

After several weeks, the phenomenon changed to only the words of songs without tunes, not unpleasant, but distracting because of their compulsive effect. After two more weeks, the sounds intensified and instead of recognizable songs, there were repetitions of gibberish that no longer could be "tuned out" or consciously altered. Gradually, over a period of months, the hallucinations reduced in intensity, but rarely did a day pass without a recurrence, particularly in quiet periods that followed times of stress or when the patient was in an intermediate state of alertness, such as driving a car. Although the ease of suppression and intelligibility of phrases varied over time, there was no substantial change in the nature of the phenomenon: repetitive cycles of lyrics without tunes.

The diagnostic workup included normal laboratory tests, magnetic resonance imaging, and single photon emission computer tomography brain scans. A conventional electroencephalogram performed during a symptom-free period was normal. Tegretol®

was not tolerated and rechallenge with triazolam for two nights did not affect the symptoms. Over a period of many months, the symptoms gradually subsided, coincident with a change from his usual decaffeinated coffee to two cups a day of regular coffee. One year after the onset, symptoms were infrequent and transient.

COMMENTS

Oliver Sacks, MD, referred to the temporal lobe as "the musical lobe of the brain," citing the classic work of Wilder Penfield who was able to provoke "a convulsive upsurge of melodies" by electrical stimulation of the temporal lobes.[3] In addition to irritative foci, another possible mechanism of auditory hallucinations has been postulated on the basis of a "release" phenomenon due to impaired sensory input associated with end-organ dysfunction or as a result of focal dysfunction in the brain or auditory pathways.[4] West advocated such a paradigm, based on Hughlings Jackson's concept of disinhibition. Thus, loss of sensory input that normally suppresses nonessential information would account for an outpouring of previously acquired memories.[5] Among distinguishing features that differentiate release phenomena of sensory impulses from irritative foci are that the former tend to be relatively continuous over long periods, are variable in their patterns, and may be influenced by purposeful acts.[6]

The present case report suggests such a mechanism of disinhibition rather than a paroxysmal seizure disorder. This patient differs from other patients with musical hallucinations in that the patient neither was deaf nor elderly and had no evidence of underlying psychiatric, alcoholic, or neurologic disease. Furthermore, the predominant symptom was lyrical rather than tuneful although both words and melodies were part of the original presentation.

After describing several cases of musical "reminiscences" in his popular book, *The Man who Mistook his Wife for a Hat and other Clinical Tales,* Dr. Sacks received more than 300 letters from sufferers, many of whom were "tormented by musical phantoms."[7] One man began to hear intrusive music when he went on an annual visit to a meditation center. He noted the music started precisely when his mind was in a "blank state."

Dr. Sacks believes that musical hallucinations are not uncommon, especially in the elderly, and although occasionally serious pathology can be found, hallucinations generally are idiopathic and benign. The condition may be underdiagnosed because patients either are embarrassed to report their symptoms or the importance of the complaint is discounted by family or physicians. It also is conceivable that some seemingly demented elderly patients may have received benzodiazepines, such as triazolam, but the association between drugs and musical hallucinations was not appreciated.

There have been only a few well-documented accounts of drug-induced musical hallucinations. One involved an elderly woman with arthritis and osteosclerosis who incessantly heard the song, "When Irish Eyes Are Smiling" until her daily dose of 12 tablets of aspirin was discontinued, presumably a form of salicylism.[8] Wengel described two depressed patients who began having musical hallucinations shortly after the initiation of tricyclic antidepressants.[1]

Triazolam, a short-acting benzodiazepine, now is the most widely prescribed hypnotic in the United States. Like all benzodiazepines, triazolam can impair the acquisition and recall of information, but in one study there was no persistent effect on memory in studies done 24 hours after ingestion.[9] Excessive alertness, paradoxical excitement, and behavioral disinhibition have been encountered in a small percentage of users and several case reports have described "traveller's amnesia" or transient global amnesia when the drug was employed by international flyers.[10-12] It was speculated that fatigue, altitude, and alcohol may have been cofactors. Visual and tactile hallucinations associated with psychosis also have been encountered with triazolam use[13] but, heretofore, no case of pure musical hallucinations. Bixler wrote, "The cognitive impairments associated with triazolam represent a spectrum of dysfunction with memory impairment/amnesia and confusion being the commoner and milder manifestations at one end of the spectrum and hallucinations and delusions being the more severe and less common manifestations at the other end."[14]

CONCLUSION

It is impossible to prove causation to triazolam in this case. Since the acute onset of symptoms coincided with release from the effects of the drug, if there was any causal effect, it was manifested as unmasking of suppressed musical memories. Unlike alcohol withdrawal symptoms or other central nervous system effects that have been attributed to this drug, the phenomenon persisted for more than a year after exposure. Although the clinical presentation in this case seems to be unique, persistent musical reminiscence as a prolonged release phenomenon should be considered among the bizzare potential complications of triazolam use. ■

References available upon request.

Dr. Nevins is a clinical associate professor of medicine, UMDNJ-New Jersey Medical School, Newark. This paper was submitted in July 1991 and accepted in September 1991. Requests for reprints may be addressed to Dr. Nevins, 354 Old Hook Road, Westwood, NJ 07675.

Ethical Aspects of Oncologic Practice

Harvey Rothberg, MD

Oncologists must consider the ethical implications of all of their efforts. The patient's welfare and the likelihood of benefit from each therapeutic maneuver should be primary concerns. The author presents a set of general principles and guidelines for the care of cancer patients and others with incurable diseases.

As medical knowledge and technology have grown, so has the ability of our profession to interfere with the pathophysiologic events of disease. Oncologists, like other physicians, must consider whether they should primarily combat disease and prolong life, i.e. increase the quantity of life, or whether they should emphasize the quality of life, which implies freedom from pain and other types of physical and emotional distress.

In oncology, efforts to fight the progression of disease are successful in some cases, and unsuccessful in others. Since active treatment often carries with it a downside of inconvenience and morbidity, the oncologist always should make a judgment as to whether a given course of action is more likely to enhance a patient's well-being or to work against it, and should advise and act accordingly. The challenge and the obligation of the oncologist is to make a careful and selective application of available therapeutic modalities. In some cases, it is difficult to know what is best, and the benefit of certain treatments or courses of action cannot always be predicted.

For many oncologists, it may be more difficult to refrain from active therapeutic management than to pursue it. But it is incumbent upon all physicians to consider the consequences of their actions, and always to proceed with a concern for what is best for the particular patient.

Ethical decision making is particularly relevant when a patient with an incurable disease approaches a terminal state. There is a common belief that in hopeless situations patients have a right to die without technology—that there should be a limit to the application of artificial support measures. But in other instances, a concerned and devoted family may feel that no effort should be spared to sustain a given patient; and, there also may be third-party individuals (right-to-life advocates, lawyers, or institutional or governmental authorities) who may press for maximal active therapeutic efforts in some of these difficult situations.

Caring for cancer patients involves complex areas of ethical decision making. On the basis of concepts derived from the medical tradition, from recent judicial decisions, and from authoritative policy statements as well as clinical experience, the author has dervied a set of general principles and guidelines that may facilitate ethical decision making and clinical management for patients and physicians.

This brief presentation is limited to the "micro-ethics" involved in the care of individual patients. It avoids consideration of important "macro-ethical" issues including whether society should pay for expensive procedures of limited efficacy, such as autologous bone marrow transplantation for refractory breast cancer or lymphoma. Also omitted is the discussion of the ethical aspects of clinical trials, which have been considered in other recent publications.[1]

GENERAL PRINCIPLES

1. The aim of medical management is to improve or maintain the patient's well-being to the maximum extent possible.

2. Practitioners must recognize the limitations of medical management.

3. Patients have the right to accept or reject proposed therapeutic measures. Patient acceptance of any therapeutic program should be on the basis of informed consent.

4. Regarding euthanasia, it is not the physician's role to hasten death; but by withholding or withdrawing therapeutic measures, he may choose to refrain from interfering with the natural processes that lead to death.[2,3,4]

5. Regarding suicide, rational adults have the right to terminate their lives; but ordinarily it is not appropriate for a physician to aid and abet a patient's suicide.* Rather, the doctor's role is to relieve suffering, thereby tending to obviate the need for suicide as a solution for personal problems.[5]

GUIDELINES FOR PRACTICE

1. A body of societal opinion has developed in the context of which critical decisions regarding clinical management can be made.[2-9]

2. Physicians always should work for a patient's well-being and benefit, and always seek to avoid what is likely to lead to needless distress.

3. Management decisions must never be made in a stereotyped or routine manner, but always with regard to the particular circumstances of the individual case.

4. Physicians should avoid mindless reflex actions and prescriptions. Physicians should not prescribe complex treatments or procedures, e.g. cancer chemotherapy, simply because they know how.

5. Physicians should consider what is the appropriate level of care for each patient. Cardiopulmonary resuscitation (CPR) status should be addressed when indicated.

6. It always is best if the patient, together with his physician, can make the critical decisions. A living will is desirable as an expression of a patient's wishes; but it is neither necessary nor sufficient for ethical decision making at the end of life. If the patient is incapable of making decisions, a durable power of attorney, or meaningful dialogue with family and others concerned, may provide the necessary input for decision making. In some cases, review and discussion with an ethics committee or other consultants may be helpful.

7. Good communication is essential if mistakes and misunderstandings are to be avoided.

8. Documentation in the clinical record is important, especially in the case of decisions that may be difficult or debatable. ■

*In exceptional cases, a greater degree of involvement by the physician may be appropriate. Physician-assisted suicide, while contrary to official medical policy as well as to law, has been considered by responsible physicians and ethicists to be acceptable in certain circumstances.

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Colonic Necrosis in the Hemolytic Uremic Syndrome

Donald Rothman, MD
Vito Gulli, MD

A previously healthy 14-year-old male survived extensive colon resection and ileostomy for acute colonic necrosis. The diagnosis of hemolytic uremic syndrome was made and intensive postoperative care was required. He made a complete recovery.

Since von Gasser first described hemolytic uremic syndrome (HUS) in 1955, hundreds of cases have been reported in the medical literature.[1,2] Presently thought to be due to some toxic agent (possibly verotoxin producing *Escherichia coli*),[3,4] this condition typically presents clinically with gastroenteritis, varying degrees of renal dysfunction, and neurological manifestations. Surgical involvement usually is supportive in nature. However, a small number of patients have required surgery for treatment of the peculiar colonic necrosis that may prove taxing and vital to the management of these seriously ill individuals.[5] We present a case report and a review of other cases treated surgically.

CASE REPORT

A previously healthy 14-year-old high school student was admitted to Riverview Medical Center on August 9, 1988, with a history of profuse watery then bloody diarrhea, bilious and mucoid vomiting, and abdominal pain for 24 hours. There had been no exposure to seafood or antibiotics. Other family members and contacts were entirely well. The previous day, he had been surfing and sustained a mild contusion to the abdomen from a boogie board. Physical examination revealed diffuse, nonlocalizing abdominal tenderness without rebound or rigidity. His temperature was normal. White blood count (WBC) was 16,400/mm^3 (90 segmentals [segs], 5 lymphs, 5 monocytes [monos]). The hematocrit was 48.3 percent, and platelets were 270,000/mm^3. Blood urea nitrogen (BUN), electrolytes, glucose, and creatinine were normal. The admitting diagnosis was gastroenteritis of possible *Salmonella* etiology. He was placed on intravenous (IV) fluids. The frequent bloody bowel movements (30 to 45/day) continued. Two days later, he was pale and acutely ill, and had slight abdominal distention and persistent pain. WBC rose to 19,000/mm^3. A gastroenterology consultation was obtained and sigmoidoscopy to 15 cm was unrevealing. Radiographs showed a nonspecific gas pattern. Because of the increasing abdominal tenderness, he was seen by a surgeon who advised laparotomy. Operative exploration through a long right paramedian incision revealed 1,000 cc of clear ascites. The small intestine was grossly normal except for the distal ileum that was inflamed, thickened, and opaque on the serosal surface. The cecum and ascending colon had a covering of thick gelatinous material. The distal transverse colon, splenic flexure, and descending colon showed a purple wall that was extremely thickened and necrotic. Lymph was seen seeping from the serosa and mesentery. The blood vessels were not grossly thrombosed. In some areas, the findings resembled Crohn's enterocolitis. The nonviable appearing portion of the colon was resected; the transverse and descending colon ends were brought out as mucus fistulae in the left upper quadrant, and a loop ileostomy was created in the right lower quadrant.

A colonic segment measured 29 cm and showed extensive hemor-



Figure 1—Gross appearance of a colonic segment measuring 29 cm.

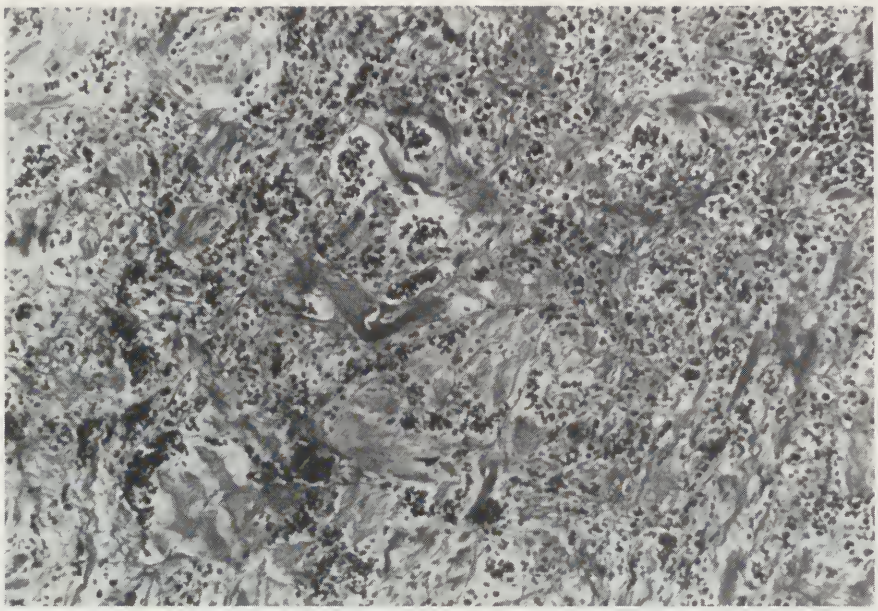


Figure 2—Photomicrograph shows full thickness colonic necrosis; no occluding fibrin microthrombi were identified.

rhage and edema throughout the tissue (Figure 1). There was patchy serosal exudate. The mucosa was diffusely sloughed and had no residual normal markings. Sectioning revealed a thinned muscularis. These changes extended to the margins of resection grossly. Microscopically (Figure 2), extensive transmural, hemorrhagic necrosis was present and included accumulation of granulocytes in focally present residual lining mucosa. No occluding fibrin microthrombi were identified.

Combined cleocin, gentamycin, and ampicillin therapy was initiated. IV fluids and plasma were given. By the first postoperative day, BUN was 39 mg%, creatinine was 3.8 mg%, platelets were 93,000/mm^3, and WBC was 26,500/mm^3. The hematocrit fell from 42 to 34 percent. Peritoneal cultures at surgery grew *Pasturella multocida* and alpha-hemolytic *Streptococcus*. A search for anaerobes, rotovirus, ova, and parasites was negative.

A diagnosis of HUS was made and the patient was transferred to Children's Hospital of Philadelphia. After a stormy course involving episodes of hypotension, anemia, oliguria, and neurological changes, the patient responded to treatment with hemodialysis. He was discharged after three weeks with no renal or neurological impairment. He made a complete recovery, had a reanastomosis, and returned to normal activity.

DISCUSSION

Although of obscure etiology, HUS has been extensively reported in the pediatric and general medical literature. Surgeons may be peripherally involved for venous access lines and dialysis shunts, but surgeons may be asked to evaluate patients for an acute abdominal process (sometimes before the diagnosis

Table. ***Listing of colonic surgical cases in HUS.***

Author	Age	Sex	Presentation	Findings	Operation	Course
Trochen[8] April 1977	2	F	Bloody diarrhea	Descending colon colitis	Resection, colostomy	Reanastomosis in 12 months
Liebhaven[9] October 1977	4¼	F	Bloody diarrhea	Perforated descending colon	Sigmoid resection, colostomy	Reanastomosis 3 months
Schwartz[10] July 1978	2½	F	Bloody diarrhea, mass, peritonitis	Gangrene mid-transverse and descending colon	Colon resection, colostomy	Reanastomosis 3 months
Smith[5] 1978	4½	F	Diarrhea, abdominal pain	Necrosis, transverse and sigmoid	Colon resection, colostomy	Reanastomosis 3 months
von Steiegmann[7] 1979	6½	F	Bloody diarrhea, abdominal pain	Gangrene, splenic flexure to sigmoid	Resection, colostomy	Reanastomosis 3 months and kidney allograft
Whitington[11] April 1979	–	M	Bloody diarrhea	Colon necrosis	Subtotal colectomy	Expired
Kendall[12] April 1984	3½	M	Bloody diarrhea, abdominal pain	Ascites, gangrenous colitis	Loop ileostomy	Expired, 5 days
Kendall[12] April 1984	2½	M	Bloody diarrhea, abdominal pain, emesis	Gangrene, right transverse descending colon	Hemicolectomy, cecostomy	Expired, 3 days
Rothman 1988	14	M	Bloody diarrhea, abdominal pain	Transverse splenic flexure necrosis	Resection, colostomy, ileostomy	Alive

of HUS has been made). The decision to operate becomes a real and critical possibility since, in extreme cases, intestinal necrosis may lead to continued toxicity and death. A review of the literature (Table) revealed eight cases where surgery was performed. Yates clearly enumerated the operative experience in HUS.[6] We found only two summary articles in surgical journals describing perforation, stricture, colonic infarction, and toxic megacolon.[5,7] In 1979, von Steiegmann and Lilly reported the first case associated with infarction.[7]

Several other patients have had laparotomy for suspected appendicitis or peritonitis.[13-15] Incidentally and obviously, the appendectomy incisions should be made adequate for thorough exploration in these cases. Smith had two other patients with HUS who had laparotomy without resection and one expired.[6] Surgery has been done for intussusception.[16,17] Late complications such as stricture, indicating the serious nature of the intestinal damage, are not addressed here.[18] The Table identifies the fascinating nature of this disease, the bizarre pathology, the peculiar predilection for the transverse, splenic, and descending colon segments, the ascites, and the need for bold incision and bold resection in very young and seriously ill children. Our case is typical, although our patient is the oldest patient in the series. If HUS becomes more widespread in the older ages, reports of similar intestinal necrosis may be forthcoming.

CONCLUSION

The surgeon may play a lifesaving role in cases of HUS by being prepared to operate and resect portions of necrotic colon to create temporary fecal diversions. ■

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How AIDS Has Shaped CDC's Prevention Policies

Ronald O. Valdiserri, MD, MPH

The Centers for Disease Control HIV prevention strategy has developed into a plan that recognizes the complexity of human behavior change, the diversity of partners needed to combat this enemy, and the importance of integrating HIV prevention efforts into other prevention, medical, and social services.

As we enter the second decade of the epidemic of human immunodeficiency virus (HIV) infection and acquired immunodeficiency syndrome (AIDS), it becomes increasingly apparent that AIDS has had, and will continue to exert, a profound impact upon our society. It has forced us to confront sensitive and often polarized views of human sexuality, to examine the painful and complex realities of substance abuse, to increase our understanding of the relationship between health and social circumstance, and to realize the limitations of purely technologic solutions to health problems for men, women, and children.

Throughout the world, in cities, towns, and villages everywhere, AIDS has been the cause of much suffering. And sadly, many more people will suffer its consequences before we halt its deadly progress. For those people and for the ones who loved them, we grieve. But, as with many painful episodes throughout human history, adversity also has a positive side—and AIDS is no exception. AIDS has taught us many valuable lessons, especially in the area of HIV prevention.

This article will review key elements of the Centers for Disease Control (CDC) strategy for HIV prevention in the United States and explain how the lessons we have learned from AIDS during its first decade have been incorporated into our current programs for HIV prevention.

The mission of CDC's HIV prevention program is twofold: to prevent HIV infection; and to reduce associated morbidity and mortality among persons who are already infected.

Because an individual's knowledge of HIV serostatus is important for both prevention efforts and the individual's well being, counseling and testing will remain an integral component of CDC's overall HIV prevention strategy. However, it is by no means the only element of CDC's plan. To describe the other components of our current HIV prevention activities, and to explain how they have been influenced by our ongoing experience with the epidemic, a discussion of several planning assumptions outlined in *CDC Plan for Preventing Human Immunodeficiency (HIV) Infection: A Blueprint for the 1990s* will be presented.

STRATEGY FOR HIV PREVENTION

Planning Assumption Number 1: "Prevention or modification of high-risk behaviors is an effective intervention to prevent HIV transmission."

As a society, we tend to have a bias toward "cure" rather than "prevention" as a solution to health problems. For many of us, the curative "magic bullet" would be the preferred resolution to the HIV epidemic, rather than a strategy that must rely on the ability of individuals to adopt and maintain safer and healthier behaviors. The reasons for this are many, not the least of which is that taking a pill or receiving an injection is easier than routinely practicing safe sex or breaking the bonds of a longstanding drug addiction. However, in the absence of curative therapy, we have relied upon behavior approaches to HIV prevention.

The first decade of the AIDS epidemic has taught us that behavioral interventions can work, and that programs can support individuals in the process of adopting safer and healthier behaviors. But we also have learned that it is important not to make generalizations about behavior change. For example, although gay men who are well integrated into social networks in large urban centers may have been successful in modifying their riskful sexual practices, we should not assume that all gay men have been equally successful. Further-

more, men who have sex with other men but do not self-identify as "gay" or "homosexual" may not even be aware of their risk of HIV infection.

This experience is being translated into new and different kinds of prevention programs. In CDC's AIDS Community Demonstration Projects, ethnographers are obtaining information from men who have sex with men but who do not self-identify as "gay," and will use this information to craft behavioral interventions that can be delivered in nontraditional settings.

Another important behavioral lesson we have learned is that behavior change is not an "all or nothing" proposition. In reality, it is more accurately described as a series of stages, where movement can be bidirectional. In other words, persons can move through various stages of change from unsafe to safer behaviors, but they also can "relapse" from safe into unsafe behaviors. We have begun to recognize that our prevention efforts must support both the adoption and the maintenance of safer behaviors. For example, a Baltimore-based project that targets the prevention of perinatal HIV transmission uses comic books with health education messages, endorsements from community role models, and a series of media messages to support women in both initiating and sustaining behaviors that will reduce the risk of acquiring and transmitting HIV infection.

Planning Assumption Number 2: "Involvement of representatives or members of communities or groups disproportionately affected by this epidemic in the planning and implementation of HIV prevention programs is important to enhance acceptance and effectiveness."

Although not a new observation, the epidemic of HIV infection has taught us that the personal perspective of the individual infected with HIV or at high risk for infection may be quite different from the perspective of the public health official who is planning HIV prevention programs. For example, public health officials recognize and support the importance of HIV counseling and testing, but many of the individuals who could most benefit from this intervention, and subsequent entry into other necessary prevention and medical services, may not share our estimation of its importance. Likewise, if cultural norms equate the condom with disease and promiscuity, how can we hope to encourage sexually active persons with that cultural perspective, to view consistent condom use in a positive light?

The importance of these observations is more than academic. Stated most simply, whether or not persons at risk for HIV infection choose to accept prevention services may mean the difference between life and death. In the same way that market specialists encourage consumers to buy products by making those products attractive and useful, CDC has actively sought the advice of persons drawn from the communities affected by HIV/AIDS to help us craft and deliver prevention programs that will be acceptable to the intended persons.

For example, to learn more about where and how to deliver HIV prevention and family planning services to women who rarely attend traditional family planning clinics, the CDC-supported San Francisco Perinatal Prevention Project conducted focus group sessions with women who were injecting drug users, worked in the sex industry, or were sexual partners of men at high risk for HIV infection. The information from these focus group sessions will be used to design programs that address the needs of these women.

The involvement of the communities affected by AIDS extends well beyond their participation in focus groups and other "consumer" surveys. In 1989, CDC began direct funding of community-based organizations (CBOs) in an effort to extend the reach of its prevention activities by enlisting the active support of organizations that have credibility with groups at increased risk for HIV infection. Presently, nearly 100 CBOs are receiving funds directly from CDC and almost 500 CBOs receive funds indirectly via state health departments. Their programs are diverse, including such activities as street outreach to injecting drug users, HIV prevention education for residents of transitional shelters, outreach to adolescents through the juvenile justice system, and door-to-door HIV information and prevention training for residents of public housing projects. By including these grassroots organizations in our national prevention efforts, we are able to extend our ability to reach persons with necessary information and skills training. Because they are community based, these organizations can begin to influence community norms in support of safer and healthier behaviors.

Planning Assumption Number 3: "The successful prevention of HIV transmission requires individual effort as well as the collective participation of national, state, and local governmental and nongovernmental organizations."

HIV prevention requires CDC to address the special needs of specific groups. But, the first decade of the epidemic also has taught us that AIDS and HIV infection are problems for all of us. We have come to realize that in order to be successful in our fight against AIDS, we must mount a broad-based societal response. In other words, HIV prevention is not just the job of state and local health departments. Schools, churches, businesses, professional groups, and other nongovernmental organizations, including CBOs, have been enlisted in our efforts to mount a national prevention campaign.

CDC encourages this collective participation in several important

ways, including support for a variety of national minority organizations; CBOs; and the United States Conference of Mayors (USCM).

In 1983, USCM established an HIV/AIDS program to address the impact of AIDS at the local level. Since 1985, they have been receiving funds from CDC enabling them to provide a forum for the transfer of newly emerging HIV prevention "technologies" to their members; to provide seed monies to emerging CBOs interested in developing AIDS prevention activities; and to provide technical assistance to CBOs in the areas of program planning, implementation, and evaluation. This successful program has provided grants and technical assistance to CBOs in nearly 75 metropolitan areas, and USCM's published case studies have been a useful source of information about the strengths and weaknesses of various prevention strategies.

In 1988, CDC directed resources to national minority organizations in an effort to broaden the base of minority organizations involved in HIV/AIDS prevention and to support national HIV prevention activities complementing state and local efforts for racial and ethnic minorities.

By broadening our prevention activities to include the USCM, national minority organizations, CBOs, and other nontraditional partners, we have greatly increased our prevention capacity. This strategy does not minimize the crucial role of state and local health departments in HIV prevention activities. Instead, it recognizes the strategic importance of diversification. Welcoming other societal partners to join our prevention efforts strengthens those efforts through the accumulation of wisdom, experience, and multiple perspectives.

Planning Assumption Number 4: "Prevention activities will be enhanced by the availability of medical and social services."

During the early years of the HIV epidemic, prevention efforts focused on providing the uninfected individual with information on the mechanics of viral transmission and how to remain free of infection. However, as we gained more experience with the groups whose behaviors placed them at risk for HIV infection, we learned that other health and medical problems were having a negative impact on our prevention activities. For example, individuals whose risk of HIV infection derives from the practice of injecting drugs and sharing injection equipment, often are unable to forego needle sharing because of the greater need to cope with the physiologic demands of addiction. Runaway adolescents living on the street and trading sex for money may engage in unsafe sexual behaviors in order to purchase food and shelter. Men and women with untreated genital ulcer disease are likely to be at greater risk for HIV infection because the ulcerative lesions on their genitals provide easy access for the virus.

These examples all underscore our growing awareness that integration of HIV prevention activities into other prevention, primary care, and social support programs will increase their effectiveness. The client benefits because a variety of services are available at a single point in time. Public health programs benefit from this integration in two ways: providing the client with additional services that will have a positive impact on reducing the risk of transmitting or acquiring HIV infection, and increasing opportunities to provide clients with the information and skills needed to avoid the transmission or acquisition of HIV infection.

Many state and local health departments have begun to address this issue by providing additional services for HIV-infected clients. A number of departments offer CD4+ testing and when indicated, referral for medical therapy. A smaller number of health department programs offer a full array of medical, psychosocial, and support services for HIV-infected persons.

In order to learn more about the benefits of integrating programs for primary HIV prevention, i.e. preventing HIV infection, with secondary HIV prevention activities, i.e. preventing associated morbidity and mortality among persons already infected, CDC is conducting a demonstration project in seven cities in the United States. This project will provide medical, psychosocial, and support services to HIV-infected clients who are identified through counseling and testing programs.

By providing additional services through counseling and testing sites, clients are less likely to become "lost" to the system, will remain in the system longer, and will be more available for follow-up counseling and intervention. Not only will we have repeated opportunities to provide these individuals and their partners with the skills they need to prevent further transmission of HIV, but we also will be able to work with their medical providers in order to reinforce behavioral messages.

CONCLUSION

We have come a long way in our understanding of HIV infection and AIDS. Our HIV prevention strategy has developed from a traditional, information-dissemination effort into a plan that recognizes the complexity of human behavior change, the diversity of partners needed to combat this common enemy, and the importance of integrating HIV prevention efforts into other prevention, medical, and social services. As we move into the second decade of this epidemic, the valuable lessons we have learned during the first decade will help us to develop programs that are more accessible and effective. ■

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The Founding of the MSNJ Auxiliary

Nancy M. Propsner, BA

The MSNJ Auxiliary was founded on June 7, 1927. Mrs. Miriam Lee Lippincott served as its first president and guided the Auxiliary in its early years. Mrs. Lippincott's medical contributions are outstanding. The MSNJ Auxiliary soon will celebrate 65 years of service to the medical community.

In the 1920s, it was common practice for physicians to have their wives and children accompany them to Medical Society of New Jersey (MSNJ) annual meetings. Many wives took this opportunity to get acquainted; lasting friendships were formed through this unofficial auxiliary.

In 1926, the idea to form an official MSNJ Auxiliary was presented by Mrs. W. Wayne Babcock to the House of Delegates at the Annual Meeting. Mrs. Babcock, chairman of the American Medical Association (AMA) Committee on Organization of the Woman's Auxiliary, told the state delegates that an Auxiliary's goal is to "act as a medium between the medical profession and the laity, to carry out such requests as are imposed upon by the AMA, by the state medical, and by the county medical societies." She added, "Any organization which gives a wife a better understanding of her husband's daily work, and . . . binds a husband and wife more closely together, is worthy of serious consideration." Mrs. Babcock explained the Auxiliary's vast potential, admitting that the Auxiliary needs, "the type that stands shoulder to shoulder with her husband . . . 100 percent proud to be connected with the medical profession."[1]

The MSNJ House of Delegates unanimously voted to organize a woman's Auxiliary. MSNJ President Lucius Donohoe, MD, appointed a special organizational committee: Mrs. Samuel Barbash, chairman; Mrs. E. R. Mulford; Mrs. M. W. Reddan; Mrs. David Weeks; Mrs. John Nevin; Mrs. Daniel Remer; Mrs. A. Haines Lippincott; and Mrs. James Hunter, Jr.

The MSNJ Auxiliary was to be patterned after existing county and state medical societies. Henry O. Reik, MD, MSNJ executive secretary and editor of the state journal, wrote to Mrs. Lippincott: "Two possible methods lay before us: One, to appoint delegates from the various counties to meet for the purpose of organizing a state Auxiliary, and then to follow that proceeding by the organization of county branches; second, to proceed directly to the organization of Auxiliaries to the county societies, and then have their delegates meet in June coincident with the meeting of the State Society for the purpose of amalgamation into a State Auxiliary."[2] The latter plan was adopted. A short address for each organizational county Auxiliary meeting was prepared; a tentative constitution and bylaws for the state and county Auxiliaries were drafted; and temporary state Auxiliary officers were appointed.

FORMATION EFFORTS

The physicians and their wives from each county were invited to attend separate organizational meetings. Dr. Reik, Mrs. Barbash, and Mrs. Lippincott were the driving force behind forming these Auxiliaries. By the 1927 Annual Meeting, not all counties had Auxiliaries. However, it was decided to organize a state Auxiliary at the 1927 Annual Meeting, with the remaining counties to form Auxiliaries.

Wives and family members of physicians convened in the Gold Room of the Chalfonte Hotel-Haddon Hall, in Atlantic City on June 9, 1927. Mrs. Barbash relayed organizing efforts at the county level; 15 county Auxiliaries had been formed and 6 counties were in the process of forming Auxiliaries (Table 1).

Mrs. Barbash welcomed the temporary state Auxiliary officers: President, Mrs. A. Haines Lippincott; 1st Vice-President, Mrs. Walter P. Conaway; 2nd Vice-President, Mrs. E.R. Mulford; Recording Secretary, Mrs. A. Longstreet Stillwell; and Treasurer, Mrs. James Hunter, Jr. A rough draft of the constitution and bylaws were reviewed; a committee was appointed to re-



Figure 1. Mrs. Miriam Lee Early Lippincott.

Table 1. ***Founding dates of New Jersey county Auxiliaries.***

County	Date of Founding
Atlantic	February 2, 1927
Bergen	May 10, 1927
Burlington	April 13, 1927
Camden	February 1927
Cape May	April 5, 1927
Cumberland	April 5, 1927
Essex	March 10, 1927
Gloucester	March 24, 1927
Hudson	May 11, 1927
Hunterdon	July 1928
Mercer	March 15, 1927
Middlesex	April 26, 1928
Monmouth	March 16, 1927
Morris	May 15, 1928
Ocean	November 1927
Passaic	November 1927
Salem	February 9, 1927
Somerset	April 14, 1927
Sussex	May 25, 1928
Union	April 13, 1927
Warren	January 10, 1928

vise them, and then permament officers were elected: President, Mrs. A. Haines Lippincott; 1st Vice-President, Mrs. Walter P. Conaway; 2nd Vice-President, Mrs. E.R. Mulford; 3rd Vice-President, Mrs. Frank Devlin; Recording Secretary, Mrs. A. Longstreet Stillwell; and Treasurer, Mrs. James Hunter, Jr.

During the first year, Auxiliary members worked diligently to increase membership; to promote the AMA's magazine *Hygeia* and various medical pamphlets; to sponsor numerous lectures on health topics; and to lecture at schools to promote proper health among schoolchildren.[3]

FIRST STATE PRESIDENT

Miriam Lee Early (Figure 1) was born on March 10, 1877, in Hightstown, to Harriet Whitmore (Ogborn) and Robert Morrison Early. She studied at Pennington Seminary, and at Northwestern University School of Oratory in Evanston, Illinois, graduating from the School of Speech in 1897.[4]

Miriam taught elocution and physical culture at Pennington Seminary, and public speaking at Swarthmore College, Pennsylvania, from 1907 to 1915. Living in Camden, she enjoyed hobbies of tennis, walking, and driving, and was a member of the Philadelphia Art Alliance, of a Philadelphia women's club, and of several literary societies.

In 1913, 36-year-old Miriam married Ahab Haines Lippincott, MD (1867-1937) (Figure 2), a 47-year-old widower. The couple settled in Camden and had one child, Barbara Lee, who died at three days of age in 1915. A well-known urologist, Dr. Lippincott served as president of the Camden County Medical Society in 1911 and of MSNJ in 1932. He was an avid supporter of his wife's endeavors.

An excellent public speaker, lecturer, and dramatic reader, Mrs. Lippincott used her talents to promote various causes, and to direct and perform in plays for

various groups; and she was active in the Little Theatre movement.

Mrs. Lippincott believed in the equality of men and women. She promoted women's suffrage with the New Jersey Women Suffrage Association (NJWSA) and, with the passage of the 19th Amendment, worked with The League of Women Voters of New Jersey (LWVNJ). Although her interest in women's voting was cultivated at Pennington Seminary, it was not until after her marriage that she became active in the cause.

Working with NJWSA in various capacities, Mrs. Lippincott was a key promoter for the ratification of the right to vote amendment. With its occurrence she stated, "It means a great day in the history of our country. It rivals the Magna Carta of England in removing the last vestige of political bigotry."[5] Mrs. Lippincott was a representative of Camden County for the Republican State Committee, responsible for organizing the county's Republican women. She was member of this Committee for almost a decade.

Mrs. Lippincott devoted over 20 years to the League of Women Voters. Most notably, she worked to allow women to serve as jurors, and was included among one of the first women jurors.

Mrs. Lippincott was an advocate of prohibition and a supporter for the passage of the 18th amendment. She served as chair of the New Jersey Committee for Law Enforcement and as a board member of the New Jersey Anti-Saloon League. She appeared before the United States Senate in 1926 and the House of Representatives in 1930, representing these organizations.

For more than 30 years, Mrs. Lippincott was a member of the Women's Club of Camden, serving as president from 1927 to 1930. The club honored Mrs. Lippincott with a contribution to the music building fund at Douglass College in memory of her daughter.

Table 2. *State Auxiliary fellowettes.*

1927-1928	Mrs. Ahab Haines Lippincott
1928-1929	Mrs. George L. Oreton
1929-1930	Mrs. James Hunter
1930-1931	Mrs. John Nevin
1931-1932	Mrs. H. Roy VanNess
1932-1933	Mrs. Charlie F. Adams
1933-1934	Mrs. Harry V. Hubbard
1934-1935	Mrs. Arthur J. Casselman
1935-1936	Mrs. Frederick A. Kinch
1936-1937	Mrs. George A. Rogers
1937-1938	Mrs. Samuel L. Salasin
1938-1939	Mrs. Don A. Epler
1939-1940	Mrs. Gerald E. McDonnel
1940-1941	Mrs. Richard J. McDonald
1941-1942	Mrs. Oswald R. Carlander
1942-1943	Mrs. J. Howard Hornberger
1943-1944	Mrs. Asher Yaguda
1944-1945	Mrs. David B. Allman
1945-1946	Mrs. Mable Dodd
1946-1947	Mrs. Frederick G. Wandall
1947-1948	Mrs. Frances Mancusi-Ungaro
1948-1949	Mrs. Robert Walker
1949-1950	Mrs. Norman Nathanson
1950-1951	Mrs. Martha Cottone
1951-1952	Mrs. Dorothy McGlade
1952-1953	Mrs. Virginia Dyer
1953-1954	Mrs. Marie Forte
1954-1955	Mrs. Marian Rauschenbach
1955-1956	Mrs. Andrew C. Ruoff, Sr
1956-1957	Mrs. Kay Sauerbrunn
1957-1958	Mrs. John C. Voss
1958-1959	Mrs. Helen Campo
1959-1960	Mrs. Peg Rowohlt
1960-1961	Mrs. Ralph K. Bush
1961-1962	Mrs. Mary Gindhart
1962-1963	Mrs. John P. Torppey
1963-1964	Mrs. Pat Booth
1964-1965	Mrs. Shirley Kunderman
1965-1966	Mrs. Lewis C. Fritts
1966-1967	Mrs. Marion Glazier
1967-1968	Mrs. Olive Zuckerman
1968-1969	Mrs. Eva Kustrup
1969-1970	Mrs. Rita MacDonald
1970-1971	Mrs. Margaret Bertland
1971-1972	Mrs. Martyna McLean
1972-1973	Mrs. Ruth Geddings
1973-1974	Mrs. Marion Abbamonte
1974-1975	Mrs. Nancy Brennan
1975-1976	Mrs. Yvonne Doggett
1976-1977	Mrs. Mildred Tarchiani
1977-1978	Mrs. Joan Gehring
1978-1979	Mrs. Bobbie Hammett
1979-1980	Mrs. Cathy Pegues
1980-1981	Mrs. Julie Grimes
1981-1982	Mrs. Phyllis Romano
1982-1983	Mrs. Linda Berger
1983-1984	Mrs. Gale Wayman
1984-1985	Mrs. Grace Gellman
1985-1986	Mrs. Bernardine Moloney
1986-1987	Mrs. Grace Holdcraft
1987-1988	Mrs. Sally Ilagan
1988-1989	Mrs. Angie Campo
1989-1990	Mrs. Sevim Omay
1990-1991	Mrs. Jane Lorber
1991-1992	Mrs. Jean Taboada

Mrs. Lippincott, a devotee of education, was affiliated with Rutgers University and New Jersey College for Women (now Douglass College), both in New Brunswick, serving as a trustee



Figure 2. Dr. Ahab H. Lippincott.



Figure 3. Seated left to right are Phyllis Romano, parliamentarian; Marion Geib, president-elect; Jean Taboada, president; Dorothy Espinola, vice-president; (standing) Mildred Rispoli, director; Chris Kline, corresponding secretary; Valerie Claps, treasurer; Dorothy Praiss, recording secretary; and Josie Ragasa, director.

and on various committees, and providing the Barbara Lee Early Lippincott Scholarship at Douglass College. In 1962, Douglass College named a dormitory in her honor. Mrs. Lippincott was the first woman appointed to the Camden City Board of Education, serving as board vice-president from 1924 to 1927. Mrs. Lippincott was a member of the Camden branch of the American Association of University Women from 1936 until her death.

She also was a charter member of the Goodwill Commission of New Jersey; active in YWCA work; involved in the world peace movement, working with two major women's pacifist organizations: the Women's International League for Peace and Freedom, and the Committee on the Cause and Cure for War; worker with the United China Relief in New Jersey; and a delegate to the 1935 International Peace Conference, in Belgium.

In 1937, at the age of 60, Mrs. Lippincott began her nine-year cancer campaign, earning the title of Cancer Lady for "working day and night, regardless of weather conditions, time or anything else."[6] She organized local units in every county and was the first state commander appointed by the American Society for the Control of Cancer, the forerunner of the New Jersey division of the American Cancer Society; she remained in that office until her death.

In addition to her medical efforts with the Auxiliary, serving as the first state Auxiliary president, president of the Camden County Auxiliary, delegate to the National Women's Auxiliary Meeting in May 1927, and a member of numerous committees, Mrs. Lippincott was director of the New Jersey State Tuberculosis Association and a trustee of Jeanes Hospital, Philadelphia, from 1940 to 1947.

On August 28, 1947, at the age of 70, Miriam Lee Early Lippincott died from a blood clot in her lung following a heart attack. She is buried in the family plot at Harleigh Cemetery in Camden, New Jersey.

CONCLUSION

From the diligent work of Mrs. Lippincott and others (Figure 3), the MSNJ Auxiliary today can boast of almost 65 years of service to the Medical Society of New Jersey. The Auxiliary now has 1,500 members in all 21 New Jersey counties. ■

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The Committee on Publication and the Editorial Board of *NEW JERSEY MEDICINE* (names listed on page 864) would like to thank the following Ad Roc Reviewers and Book Reviewers for their contributions to the journal:

David I. Canavan, MD
Donald J. Cinotti, MD
Vincent Cirillo
Dennis R. Fillippone, MD
Barbara Irwin, MLS
James H. Jacoby, MD
Vincent A. Maressa, JD
Vincent K. McInerney, MD
Alan H. Wolff, MD

HOUSING APPLICATION

226th ANNUAL MEETING
THE MEDICAL SOCIETY OF NEW JERSEY
MAY 3-6, 1992

TRUMP TAJ MAHAL CASINO/RESORT
1000 BOARDWALK AT VIRGINIA AVENUE, ATLANTIC CITY, NJ 08401
RESERVATION DEPARTMENT 1/800/825-8786

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Address _____

City _____ State _____ Zip _____

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Date of Arrival _____ Time _____

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A one-night deposit (equivalent to room rate) is required with all reservation requests. Please send check or money order payable to the **TRUMP TAJ MAHAL CASINO/RESORT** or complete the following:

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SCHEDULE OF RATES SUBJECT TO 13% TAX
☐ SINGLE **$115** ☐ DOUBLE **$115** *(Reservations must be received prior to April 2, 1992)*
Extra Person **$25**
☐ One-Bedroom Suite **$275 per day**
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PARKING: FREE PARKING TO REGISTERED GUESTS. One car per room.

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Atlantic City, New Jersey 08401
Tel: **1/800/825/8786**

DOCTORS' NOTEBOOK

TRUSTEES' MINUTES

A regular meeting of the MSNJ Board of Trustees was held on October 20, 1991, at the executive offices in Lawrenceville. Detailed minutes are on file with the secretary of your county society. A summary of significant actions follows:

President's Report.

1. News Items. Noted the following: success of the "Medicine and the Media" seminar cosponsored by MSNJ and the Auxiliary; representation of 16 counties at the Council of County Medical Society Presidents held on September 25, 1991, where membership recruitment was one of the major topics on the agenda and where counties were asked to establish a committee to be charged with contacting nonmember women physicians and international medical school graduate physicians; possible funding for a medical student school scholarship; success of the Camden County Medical Society's legislative breakfast attended by 70 physicians and 23 legislators; retraining courses for HIV-positive health care workers and physicians; and Project Pennsylvania that seeks to recruit and recredential retired or semi-retired physicians to provide medical care on a voluntary basis to the medically indigent population.

2. Pennsylvania Medical Society (PMS) Annual Meeting. Commented on the concerns of MSNJ and PMS: PMS has no limitation on the number of years a physician can serve on the AMA delegation whereas MSNJ has a limit to the number of terms; the president of PMS does not act as chairman of the Board of Trustees whereas MSNJ has combined the two duties; unified membership (compulsory AMA membership) brought about a decline in PMS membership; and various campaigns by both societies to recruit women physicians, young physicians, medical school faculty members, international medical school graduates, and residents.

Executive Director's Report.

1. MSNJ Membership. Received for its information, the membership report as of September 30, 1991, with a trend of increasing membership.

2. MSNJ Financial Statements. Reviewed and approved the financial statements for the periods ending August 31, 1991, and September 30, 1991.

3. Health Care Financing Administration (HCFA). Noted that the deadline for the survey was extended to October 31, 1991.

4. Resource-Based Relative Value Scale (RBRVS). Noted the following: agreed to continue to work with federal legislators to overcome the actions of HCFA (a proposed 16 percent reduction in the Medicare conversion factor); Churchill L. Blakey, MD, will represent MSNJ at the CPT Evaluation and Management Conference dealing with new codes for office evaluation and management services; and copies of the phase II procedural rebundling project will be sent to specialty societies for review of the codes.

5. State Board of Medical Examiners (SBME). Noted the following: SBME will be requested to consult with appropriate specialty societies before proceeding with proposed medical standards governing screening and diagnostic medical testing offices; the case involving physician assistants is expected to be argued in the Appellate Division in December; a restraining order was issued and SBME was directed to revise the license renewal application questionnaire.

6. Brachfeld versus Medical Inter-Insurance Exchange of New Jersey (MIIENJ). Authorized an explanatory mailing to all holders of MIIENJ subordinated loans as of September 19, 1990, as well as to county and specialty societies informing them of the court action and recommending that members review the notice carefully and make an informed decision. (Dr. Jonas Brachfeld has brought a class action suit against MIIENJ, alleging breach of the subordinated loan agreements because MIIENJ paid dividends to 1977 policyholders; the subordinated loan money was used to form the surplus of the company. The suit asserts that MIIENJ should not have paid the dividends without redeeming the loans.) Noted that the position of MSNJ and MIIENJ is that the action is without merit and that only those members who no longer are insured by MIIENJ may benefit from this litigation.

7. Physician Income. Received information on physician income that was compiled by Mr. Neil Weisfeld; the value of the data in discussing the issue of health care costs with legislators was reiterated by Dr. Riggs.

Specialty Reports. Received for its information reports from the University of Medicine and Dentistry; the Academy of Medicine of New Jersey; and the MSNJ Auxiliary.

NJ Hospital Association. Received a report on the following from Mr. Louis P. Scibetta: hospital audits; joint executive

committee meeting between MSNJ and the Hospital Association; and for-profit and nonprofit disclosure legislation (A-5161 and S-3696).

State Board of Medical Examiners (SBME). Agreed to seek an invitation for MSNJ to serve on a committee to establish a policy statement on HIV testing and Mr. Weisfeld and Dr. Palace will attempt to clarify SBME intent concerning the fee for developing summaries of patient records being sent to patients upon request.

Council on Legislation. Approved the following recommendation:

That the Board of Trustees' policy on the introduction of legislation be revised to read as follows:

In consequence of an extended analysis of the technical difficulties involved in the preparation and presentation of sound legislation, and upon the advice of legislative council, all committees and agencies of MSNJ wishing to present legislation for enactment hereafter should formally notify the Council on Legislation of that intent and supply it with the necessary information and materials as soon as possible in advance of the official beginning of the next legislative year.

Also, voted to change the categories of official MSNJ positions regarding bills currently in the Legislature; the new positions are:

Active Support: All-out support for the measure.

Active Opposition: All-out opposition for the measure.

Support with Amendment: To indicate that the approval of the Society is subject to the revision of the specified unsatisfactory elements of the bill.

No Position: Considered, but not regarded as significant or relevant to the proper interest of the Society.

And, approved all the positions recommended by the Council on Legislation.

JEMPAC/MedAC. Urged physicians to financially support MedAC.

Audit Review Commitee. Approved the following recommendations:

That the audited financial statements be accepted and a copy thereof be forwarded to each component society.

That Ernst & Young be continued as the external auditors.

New Business.

1. Third-Party Reviewers. Approved the following recommendations:

That MSNJ meet with the New Jersey Hospital Association to discuss the issue of nonphysician reviewers; and

That a letter be sent to the State Board of Medical Examiners from the Board of Trustees, again requesting that all quality and utilization review of medical charts be performed by New Jersey licensed physicians in the same specialty as the physician being cited.

2. Confidentiality of Patient Information. Approved the following recommendation:

That the membership of MSNJ be advised in writing of the State Board of Medical Examiners' position on the release of confidential patient information to insurance company representatives.

3. Medicare Reimbursement. Approved the following recommendations:

That the issue of Medicare reimbursement be submitted to the Council on Public Relations, with the

1992 MSNJ Annual Meeting Proposed Daily Schedule

Saturday, May 2, 1992

3:30 p.m. Board of Trustees' Meeting

Sunday, May 3, 1992

8:00 a.m. Registration Opens
9:30 a.m. Message Center Opens
10:00 a.m. Educational Program
11:30 a.m. Exhibits Open
2:00 p.m. House of Delegates
3:30 p.m. Reference Committee Meetings

Monday, May 4, 1992

8:00 a.m. Registration Opens
8:00 a.m. Message Center Opens
8:30 a.m. Exhibits Open
9:00 a.m. House of Delegates (Election)
12:00 noon Golden Merit Award Ceremony and Reception
2:30 p.m. Reference Committee Meetings
5:00 p.m. JEMPAC Political Forum
5:45 p.m. JEMPAC Wine and Cheese Reception
6:30 p.m. Camden County Medical Society Reception

Tuesday, May 5, 1992

8:00 a.m. Registration Opens
8:00 a.m. Message Center Opens
8:30 a.m. Exhibits Open
9:00 a.m. House of Delegates
1:30 p.m. House of Delegates
2:00 p.m. Exhibits Close
7:00 p.m. Inaugural Reception and Dinner

Wednesday, May 6, 1992

8:00 a.m. Registration Opens
8:00 a.m. Message Center Opens
8:30 a.m. General Session (Educational Program)
1:00 p.m. Board of Trustees' Meeting

suggestion that their current efforts be expanded;

That the Council on Legislation and JEMPAC jointly exert pressure on New Jersey lawmakers to seek legislative solutions to the Medicare muddle;

That the MSNJ staff prepare a white paper on Medicare reimbursement for distribution to the membership, to be used as a guideline for constructive action.

UMDNJ NOTES

$16.5 million EOHSI building dedicated in Piscataway. New Jersey moved one step closer to a healthier environment with the opening of a new $16.5 million building to house the Environmental and Occupational Health Sciences Institute (EOHSI), a joint project of the University of Medicine and Dentistry of New Jersey (UMDNJ) and Rutgers, The State University of New Jersey.

EOHSI was established in 1986 to focus research on environmental and occupational health issues. It is directed by Dr. Bernard Goldstein, chairman of the Department of Environmental and Community Medicine at UMDNJ-Robert Wood Johnson Medical School.

UMDNJ surgeon pioneers 'imaged' chest surgery technique. A surgeon at UMDNJ-Robert Wood Johnson Medical School, New Brunswick, is believed to be the first in the nation to perform radical lung cancer surgery without opening the patient's chest cavity. The surgeon, Dr. Ralph Lewis, operated on a 55-year-old woman and pulled her entire upper left lung lobe through a small incision in the chest with the aid of a video-imaging camera and specially designed instruments. The procedure is called imaged thoracoscopic surgery.

Much like arthroscopic surgery of the knee, the procedure uses a miniature computerized video camera and only small incisions. It requires significantly less recovery time than traditional chest surgery and leaves the patient with tiny scars rather than a scar the width of the chest.

Dr. Lewis, clinical professor of thoracic surgery at the medical school, performed the surgery at Robert Wood Johnson University Hospital, the core teaching affiliate of the medical school.

Heikkila Parkinson's Disease Center opens. For Joseph Dawley, painting the portrait of a deceased scientist who dedicated his life to curing Parkinson's disease was both a challenge and a triumph. Mr. Dawley, 55, a nationally known artist, has had Parkinson's disease for 16 years. His oil portrait of Dr. Richard Heikkila, a world-class researcher who was murdered last January, was unveiled; the unveiling marked the opening of the Richard E. Heikkila, PhD, Advanced Center for Parkinson's Disease. Dr. Heikkila had been professor of neurology and pharmacology at the medical school and an internationally recognized researcher of Parkinson's disease. The Center is located at the Department of Neurology of the UMDNJ-Robert Wood Johnson Medical School. It is supported by a $500,000 grant from the American Parkinson's Disease Association.

Study shows zinc may retard immunity boost. The common belief that zinc supplements can boost the immune system is not true for healthy elderly people. In fact, zinc supplements may retard improvements in immunity. Researchers at UMDNJ-New Jersey Medical School, Newark, came to this conclusion after finishing a year-long study of the effects of zinc supplements on 63 elderly people at three senior citizen centers in Bergen County. Elderly subjects were studied because their immune systems tend to decline with age.

Of the 63 participants, 20 persons were given 15 mg of zinc daily (the recommended daily dosage) and 19 persons were given 100 mg daily. Placebos were given to 24 other participants. All 63 participants were given a daily capsule containing vitamins and minerals to ensure that they were receiving the same quantity of vitamins and minerals other than zinc.

The immune systems of all participants were tested before the study and again at 3-, 6-, and 12-month intervals. Blood samples and skin tests were used to determine the strength of patients' immune systems at each interval.

The research showed that zinc supplements slowed the improvement seen in the immume system. In all cases, the immune systems were getting stronger, but the immune systems of those taking placebos were improving much faster.

The researchers suspect that multinutrient vitamins ultimately may have been responsible for enhancing immunity because they were the common denominator in all subjects. The study was led by Dr. John Bogden, professor of preventive medicine and community health at UMDNJ. □

Stanley S. Bergen, Jr, MD

ARE YOU MOVING?

If so, please send a change of address to *NEW JERSEY MEDICINE,* Medical Society of New Jersey, Two Princess Road, Lawrenceville, NJ 08648, at least six weeks before you move.

The following physicians have written to the executive offices of MSNJ seeking information on opportunities for practice in New Jersey. If you are interested in information concerning these physicians, we suggest you make inquiries directly to them.

CANDIDATES FOR MSNJ OFFICES

If you are interested in becoming an officer, trustee, or member of the AMA Delegation, a new opportunity is available for you. The Nominating Committee will meet on Wednesday, February 5, 1992, to consider candidates. We will consider members other than those recommended by county medical societies and nominating delegates for any of these offices.

If you wish to be considered, please contact your county medical society or the Medical Society of New Jersey (609/896-1766) for the necessary forms.

This is a real opportunity for grassroots candidate development and we urge you to use it.

MEETINGS OF THE BOARD OF TRUSTEES of the Medical Society of New Jersey

December 15, 1991
January 19, 1992
February 9, 1992
March 15, 1992
April 15, 1992

Meetings of the Board of Trustees are open to all physicians. The meeting on March 15, 1992, is an OPEN FORUM, to allow physicians the opportunity to stand up and be heard. If you would like to attend the OPEN FORUM, please contact Diana Gore, MSNJ headquarters, 609/896-1766.

Cardiology

Alan E. Kravitz, MD, 26900 Cedar Rd., #304, Beachwood, OH 44122. Jefferson 1969. Also, internal medicine. Board certified. Also, board certified (IM). Group or partnership. Available.

Internal Medicine

Thomas F. De Blasio, MD, 100 Franklin St., Apt. 8B8, Morristown, NJ 07960. St. George's 1985. Board eligible. Solo or partnership. Available July 1992.

Sheryl S. Hertel, MD, 6205 Brogan Pl., St. Louis, MO 63128. St. Louis 1986. Also, pediatrics, Board certified. Board eligible (PED). Group. Available.

Alan E. Kravitz, MD, 26900 Cedar Rd., #304, Beachwood, OH 44122. Jefferson 1969. Also, cardiology. Board certified. Also, board certified (C). Group or partnership. Available.

Cynthia K. Menack, MD, 3132 Perry Ave., Apt. 2A, Bronx, NY 10467. Mount Sinai 1989. Board eligible. Group practice or medical clinics. Available July 1992.

John Musico, MD, 262 Pine Valley Rd., Dover, DE 19901. St. George 1988. Board eligible. July 1992.

Obstetrics/Gynecology

Dennis Tumbokonm, MD, PO Box 476, Kimball, WV 24853. University of the East. Board eligible. Solo. Available.

Pediatrics

Donna Churlin, MD, 55 Montgomery St., Bloomfield, NJ 07003. UMDNJ 1987. Board eligible. Partnership or group in central New Jersey (Essex, Union, or Morris counties). Available.

Sheryl S. Hertel, MD, 6205 Brogan Pl., St. Louis, MO 63128. St. Louis 1986. Also, internal medicine. Board eligible. Board certified (IM). Group. Available.

Radiation Oncology

Carol L. Kornmehl, MD, 133 Wyncrest Rd., Marlboro, NJ 07746. SUNY-Downstate 1984. Board certified. Group, partnership, solo. Available.

Surgery

Victoria Lee, MD, 459 South St., #204, Fitchburg, MA 01420. Howard 1981. Board certified. Group, HMO, partnership. Available.

CONTINUING EDUCATION

DERMATOLOGY

January

1 **Dermatology Grand Rounds**
8 6-9 P.M.—Rutgers Community
15 Health Plan, New Brunswick
22 *(UMDNJ)*
29

14 **Monthly Meeting**
7 P.M.—Schering Corporation, Kenilworth
(Dermatological Society of New Jersey and AMNJ)

February

5 **Dermatology Grand Rounds**
12 6-9 P.M.—Rutgers Community
19 Health Plan, U.S. Route 1,
26 New Brunswick
(UMDNJ)

11 **Monthly Meeting**
7 P.M.—Schering Corporation, Kenilworth
(Dermatological Society of New Jersey and AMNJ)

INFECTIOUS DISEASE

January

3 **Inter-Jersey Infectious**
10 **Disease Rounds**
17 Hackensack Medical Center,
24 Newark Beth Israel Medical
31 Center, St. Joseph's Hospital and Medical Center, Overlook Hospital, and University Hospital
(UMDNJ and AMNJ)

6 **AIDS Training and Resource Program for Hospital Health Educators**
1:30-2:30 P.M.—Essex County Hospital Center, Cedar Grove
(AMNJ)

9 **AIDS Training and Resource Program for Hospital Health Educators**
1:30-2:30 P.M.—Essex County Hospital Center, Cedar Grove
(Essex County Hospital Center)

22 **AIDS Training and Resource Program for Hospital Health Educators**
12 Noon-1 P.M.—Medical Center of Ocean County, Point Pleasant
(AMNJ)

23 **AIDS Training and Resource Program for Hospital Health Educators**
12 Noon-1 P.M.—Zurbrugg Hospital, Riverside
(AMNJ and NJDOH)

29 **AIDS Training and Resource Program for Hospital Health Educators**
1-2 P.M.—Kimball Medical Center, Lakewood
(AMNJ and NJDOH)

29 **Identification and Management of Asymptomatic HIV Infection**
11:30 A.M-12:30 P.M.—Hamilton Hospital, Hamilton
(AMNJ)

31 **Diagnosis and Treatment of AIDS**
8:30-9:30 A.M.—Chilton Memorial Hospital, Pompton Plains
(AMNJ and NJDOH)

February

7 **Inter-Jersey Infectious**
14 **Disease Rounds**
21 Hackensack Medical Center,
28 Newark Beth Israel Medical Center, St. Joseph's Hospital and Medical Center, Overlook Hospital, and University Hospital: Rotating locations
(UMDNJ and AMNJ)

12 **Identification and Management of Asymptomatic HIV Infection**
1-2 P.M.—VA Medical Center, Lyons
(AMNJ and NJDOH)

19 **AIDS: Ethical Issues**
8:30-9:30 A.M.—West Jersey Hospial System, Voorhees
(AMNJ and NJDOH)

26 **Diagnosis and Treatment of AIDS**
2:30-3:30 P.M.—Trenton Psychiatric Hospital, Trenton
(AMNJ and NJDOH)

MEDICINE

January

1 **Endocrinology Monthly Meeting**
6-9 P.M.—Holiday Inn, Newark Airport, Newark
(AMNJ)

1 **Endocrinology Grand Rounds**
8 11:30 A.M.-1 P.M.—VA Medical
15 Center, East Orange
22 *(AMNJ)*
29

1 **Interhospital Endocrine**
8 **Rounds**
15 3:30-5:30 P.M.—Newark Beth
22 Israel Medical Center,
29 University Hospital, VA Medical Center, and United Hospitals Medical Center
(AMNJ)

3 **Health Promotion for People with Down's Syndrome**
12:30-1:30 P.M.—Somerset Medical Center, Somerville
(AMNJ and Developmental Disabilities Center)

6 **Occupational Asthma in New Jersey**
11:30 A.M.-1 P.M.—East Orange General Hospital
(AMNJ)

8 **Diabetic Nephropathy**
11:30 A.M.-12:30 P.M.—Hamilton Hospital, Hamilton
(AMNJ)

8 **Prevention of Lower Extremity Amputations**
1-2 P.M.—VA Medical Center, Lyons
(AMNJ and NJDOH)

PHILADELPHIA HEART INSTITUTE
at Presbyterian Medical Center

Cardiology Update

designed for the physician and provides an intensive survey of the current status of clinical cardiology . . .

Wednesday, January 8, 1992

Syncope: Simple Faint or Cardiac Arrest

Moderator: Leonard N. Horowitz, M.D.

3:00-3:30 Hypotensive Problems: Diagnosis and management—
Steven J. Nierenberg, M.D.

3:30-4:00 Cardiac arrhythmias and conduction problems causing syncope—
Leonard N. Horowitz, M.D.

4:00-5:00 Case Presentations—***Hope Helfeld, D.O.***
Panel Discussion—***Charles D. Gottlieb, M.D.,***
Terry Langer, M.D., Marvin Rosner, D.O.

- *Case Presentations and Panel Discussions*
- *CME Credits**
- *No Registration Fee*
- *Call for Reservations 215-662-8627*

Scheie Auditorium
Presbyterian Medical Center
39th & Market Streets
Philadelphia, Pennsylvania 19104

The Philadelphia Heart Institute at Presbyterian Medical Center is an affiliate of the University of Pennsylvania.

**Presbyterian Medical Center designates this continued medical education activity for 2 credit hours in Category I of the Physicians' Recognition Award of the American Medical Association and the Pennsylvania Medical Society Membership requirement. Nine sessions, 18 credits.*

9 **Health Promotion for People with Down's Syndrome**
8:30-9:30 A.M.—St. Peter's Medical Center, New Brunswick
(AMNJ)

15 **Pulmonary Grand Rounds**
11:30 A.M.-12:30 P.M.—Newcomb Medical Center, Vineland
(AMNJ)

15 **Diabetes-Related Cardiovascular Disease**
10-11 A.M.—Hunterdon Developmental Center, Clinton
(AMNJ and NJDOH)

15 **Diabetes-Related Cardiovascular Disease**
11:30 A.M.-12:30 P.M.—Rahway Hospital, Rahway
(AMNJ and NJDOH)

15 **Thyroid Diseases**
2:30-3:30 P.M.—Ancora Psychiatric Hospital, Hammonton
(AMNJ)

15 **Intensive Review of Annual**
22 **Medicine**
29 4-7 P.M.—University Hospital, Medical Education Bldg., New Brunswick
(AMNJ and UMDNJ)

15 **Fluid and Electrolyte Imbalance**
10:30-11:30 A.M.—St. Mary's Hospital, Passaic
(AMNJ)

16 **Thyroid Dysfunction in Clinical Practice**
1:30-2:30 P.M.—Essex County Hospital Center, Cedar Grove
(AMNJ)

17 **Medical Problems in the Elderly**
10-11 A.M.—Marlboro Psychiatric Hospital, Marlboro
(AMNJ)

17 **Juvenile Onset Diabetes, Medical and Physical Aspects**
12 Noon-1 P.M.—South Jersey Hospital System, Bridgeton
(AMNJ)

17 **Juvenile-Onset Diabetes**
12 Noon-1 P.M.—South Jersey Health System, Bridgeton
(South Jersey Hospital System)

17- **Winter Weekend: Family**
20 **Practice**
Great Gorge
(NJ Academy of Family Physicians)

21 **General Membership Meeting**
All day—Ramada Inn, Clark
(NJ State Society of Anesthesiologists)

22 **Hypertension**
2:30-3:30 P.M.—Ancora Psychiatric Hospital, Hammonton
(AMNJ)

27 **Anemia in the Elderly**
1-2 P.M.—New Lisbon Developmental Center, New Lisbon
(AMNJ)

28 **Health Promotion for People with Down's Syndrome**
8:30-9:30 A.M.—Newark Beth Israel Medical Center, Newark
(AMNJ)

29 **Diabetes-Related Cardiovascular Disease**
9-10 A.M.—Warren Hospital, Phillipsburg
(AMNJ and NJDOH)

29 **Anesthesiology for Laser Surgery**
10:30-11:30 A.M.—Christ Hospital, Jersey City
(AMNJ)

February

5 **Current Chemotherapy**
10:30-11:30 A.M.—St. Mary's Hospital, Passaic
(St. Mary's Hospital)

5 **Endocrinology Monthly Meeting**
6-9 P.M.—Holiday Inn, Newark Airport, Newark
(AMNJ)

5 **Endocrinology Grand Rounds**
12 11:30 A.M.-1 P.M.—VA Medical
19 Center, East Orange
26 *(AMNJ)*

5 **Interhospital Endocrine**
12 **Rounds**
19 3:30-5:30 P.M.—Newark Beth
26 Israel Medical Center, University Hospital, VA Medical Center, and United Hospitals Medical Center
(AMNJ)

5 **Intensive Review of Annual**
12 **Medicine**
19 5-7 P.M.—University Hospital,
26 Medical Education Bldg., New Brunswick
(AMNJ and UMDNJ)

5 **Diabetic Nephropathy**
11:30 A.M.-12:30 P.M.—Rahway Hospital, Rahway
(AMNJ and NJDOH)

6 **Winter Meeting: NJ Gastroenterological Society**
6:30 P.M.—Short Hills Hilton, Short Hills
(AMNJ)

6 **Health Promotion Throughout the Life Span**
3-4 P.M.—Burlington County Memorial Hospital, Mount Holly
(Burlington County Memorial Hospital)

6 **Psychiatric Emergencies**
1:30-2:30 P.M.—Essex County Hospital Center, Cedar Grove
(AMNJ)

7 **Health Promotion Throughout the Life Span**
12 Noon-1 P.M.—Monmouth Medical Center, Long Branch
(Monmouth Medical Center)

7 **Camouflaged Medical Illness**
12 Noon-1 P.M.—South Jersey Hospital System, Bridgeton
(AMNJ)

10 **Esophageal and Swallowing Syndrome**
7-8 P.M.—Wallkill Valley Hospital, Sussex
(AMNJ)

11 **Health Promotion Throughout the Life Span**
12 Noon-1 P.M.—The Mountainside Hospital, Montclair
(The Mountainside Hospital)

11 **Diabetic Nephropathy**
11 A.M.-12 Noon—West Jersey Health System, Voorhees
(AMNJ and NJDOH)

12 **Glaucoma Update**
10:30-11:30 P.M.—St. Mary's Hospital, Passaic
(AMNJ)

12 **Diabetic-Related Cardiovascular Disease**
9-10 A.M.—Elizabeth General Medical Center, Elizabeth
(AMNJ and NJDOH)

12 **Diabetic Retinopathy**
12 Noon-1 P.M.—Memorial Hospital of Salem County
(AMNJ and NJDOH)

12 **Medical Problems in the Elderly**
8-9 A.M.—Barnert Hospital, Paterson
(Barnert Hospital)

17 **Medical Problems in the Elderly**
12 Noon-1 P.M.—Memorial Hospital of Burlington County, Mount Holly
(Memorial Hospital)

Hahnemann University

Department of Medicine Grand Rounds
Wednesdays 8:30 a.m.-9:30 a.m.

January-March 1992

JANUARY 1992

January 8, 1992

THE USE OF CATHETER ABLATION FOR TREATMENT OF PATIENTS WITH SVT
Melvin M. Scheiman, M.D.
Professor of Medicine
University of California
Division of Cardiology
Moffett/Long Hospital
San Francisco, CA

January 15, 1992

INFLAMMATORY BOWEL DISEASE
Harris R. Clearfield, M.D.
Professor of Medicine
Director, Division of Gastroenterology
Hahnemann University

January 22, 1992

CONVERSIONS FROM CHRONIC TO ACUTE CORONARY SYNDROMES
James T. Willerson, M.D.
Professor and Chairman
Department of Internal Medicine
University of Texas Medical School
Houston, TX

CONVENTIONAL ANTITHROMBOTIC THERAPY (ASPIRIN & WARFARIN) IN PRIMARY & SECONDARY PREVENTION OF CORONARY ARTERY DISEASE
James H. Chesebro, M.D.
Professor of Medicine
Mayo Medical School
Consultant in Cardiovascular Diseases
Mayo Clinic
Rochester, MN

January 29, 1992

To be announced

FEBRUARY 1992

February 5, 1992

PREVENTION OF RENAL FAILURE IN THE GERIATRIC PATIENT
Michael F. Michalis, M.D.
Professor of Clinical Medicine
New York Medical College
Director, Division of Nephrology
Lenox Hill Hospital

February 12, 1992

GENITAL HERPES
Lawrence Corey, M.D.
Professor of Laboratory Medicine, Microbiology and Medicine
Head, Virology Division
University of Washington
Seattle, WA

February 19, 1992

CUTANEOUS MANIFESTATIONS OF SYSTEMIC DISEASE
Cherie M. Ditre, M.D.
Assistant Professor of Medicine
Division of Dermatology
Hahnemann University

February 26, 1992

CARDIOVASCULAR DISORDERS AND ATHEROSCLEROSIS IN POST-MENOPAUSAL WOMEN
Jay Michael Sullivan, M.D.
Professor of Medicine
Chief, Division of Cardiovascular Diseases
University of Tennessee College of Medicine
Memphis, TN

MARCH 1992

March 4, 1992

CLINICAL PATHOLOGICAL CONFERENCE
Edward Dimitry, M.D.
Chief Resident, Department of Medicine
Hahnemann University
Cathy Jensen, M.D.
Chief Resident, Department of Medicine
Hahnemann University
Richard Maniglia, M.D.
Chief Resident, Department of Medicine
Hahnemann University
Jay Patel, M.D.
Chief Resident, Department of Medicine
Hahnemann University

March 11, 1992

CARDIOLOGY—ISSUES AND ANSWERS FOR THE 90's
Sylvan L. Weinberg, M.D.
Clinical Professor of Medicine
Wright State University
Dayton, OH

March 18, 1992

OCULAR MANIFESTATIONS OF AUTOIMMUNE DISEASE
Stephen Sinclair, M.D.
Professor of Ophthalmology
Vice Chairman, Department of Ophthalmology
Hahnemann University

March 25, 1992

To be announced

Hahnemann University Department of Medicine
Wednesday Medical Seminar Series
8:30 a.m.-3:30 p.m.

January 21-22, 1992
ANTITHROMBOTIC THERAPY IN CORONARY ARTERY DISEASE

February 11-12, 1992
DIAGNOSIS AND TREATMENT OF SEXUALLY TRANSMITTED DISEASES

Seminar Directors:

William S. Frankl, M.D.
Professor of Medicine and Chairman
Department of Medicine

Allan B. Schwartz, M.D.
Professor of Medicine
Director, Continuing Medical Education for the Department of Medicine

Location:

Classroom C (Alumni Hall)
2nd Floor New College Building
Hahnemann University 15th Street Entrance
15th & Vine Streets
Philadelphia, PA

As an organization accredited by the Accreditation Council for Continuing Medical Education (ACCME), Hahnemann University designates this continuing medical education activity as Category 1 of the Physician's Recognition Award of the American Medical Association. One credit hour may be claimed for each hour of participation by the individual physician.

For information, call the Office of Continuing Education at (215) 448-8263

19 **Prevention of Lower Extremity Amputations**
10-11 A.M.—Hunterdon Developmental Center, Clinton
(AMNJ and NJDOH)

19 **Diabetes in Pregnancy**
10:30-11:30 A.M.—St. Mary's Hospital, Passaic
(AMNJ and NJDOH)

19 **Health Promotion Throughout the Life Span**
9-10 A.M.—Warren Hospital, Phillipsburg
(Warren Hospital)

19 **Diabetic Nephropathy**
1:30-2:30 P.M.—Central New Jersey Medical Group, Somerset
(Central New Jersey Medical Group)

19 **Managing Stress Effectively**
2:30-3:30 P.M.—Ancora Psychiatric Hospital, Hammonton
(Hammonton)

20 **Medical Problems in the Elderly**
12 Noon-1 P.M.—St. Mary's Hospital, Passaic
(St. Mary's Hospital)

20-23 **Lower Extremity Prosthetics and Orthotics**
8-5 P.M.—Kessler Institute, West Orange
(Kessler Institute)

24 **Functional Assessment of the Elderly**
1-2 P.M.—New Lisbon Developmental Center, New Lisbon
(AMNJ)

26 **Living Wills**
10:30-11:30 A.M.—Christ Hospital, Jersey City
(AMNJ)

OBSTETRICS/GYNECOLOGY

January

8 **Menopause**
10:30-11:30 A.M.—St. Mary's Hospital, Passaic
(AMNJ)

15 **Diabetes in Pregnancy**
1:30-2:30 P.M.—Central New Jersey Medical Group, Somerset
(Central NJ Medical Group)

February

6 **Diabetes in Pregnancy**
1:30-2:30 P.M.—Essex County Hospital Center, Cedar Grove
(AMNJ)

15 **Diabetes in Pregnancy**
1:30-2:30 P.M.—Central New Jersey Medical Group, Somerset
(AMNJ)

19 **Diabetes in Pregnancy**
10:30-11:30 A.M.—St. Mary's Hospital, Passaic
(AMNJ and NJDOH)

ONCOLOGY & RADIATION ONCOLOGY

January

16 **Tumor Board Conference**
12:15-1:15 P.M.—Mercer Medical Center, Trenton
(Mercer Medical Center)

22 **Cocktail Reception**
6:30-9 P.M.—The Manor, West Orange
(Radiation Oncology Section, AMNJ)

February

5 **Current Chemotherapy**
10:30-11:30 A.M.—St. Mary's Hospital, Passaic
(AMNJ)

20 **Tumor Board Conference**
12:15-1:15 P.M.—Mercer Medical Center, Trenton
(Mercer Medical Center)

20 **Cocktail Reception**
6:30-9 P.M.—Hyatt Regency, Route 27, New Brunswick
(Head and Neck Oncology Section, AMNJ)

RADIOLOGY

January

16 **Small Bowel Disease: MRI Conference and Case Presentation**
7:30-9:30 P.M.—Saint Barnabas Medical Center, Livingston
(NJ Institute of Ultrasound in Medicine, Radiological Society of New Jersey and Diagnostic Radiology Section, AMNJ)

16 **Radiology Lecture**
1:30-5 P.M.—Saint Barnabas Medical Center, Livingston
(Saint Barnabas Medical Center)

February

20 **Radiology Lecture**
1:30-5 P.M.—Saint Barnabas Medical Center, Livingston
(Saint Barnabas Medical Center)

20 **MRI Conference and Case Presentation**
7:30-9:30 P.M.—Saint Barnabas Medical Center, Livingston
(Radiological Society of New Jersey and Diagnostic Radiology Section, AMNJ)

Physician Seminar: December 18, 1991
2 P.M.-5 P.M. 7 P.M.-10 P.M.
Medical Society of New Jersey
Two Princess Road, Lawrenceville, NJ 08648

Pennsylvania Blue Shield has scheduled a seminar to discuss with physicians important changes in Medicare that will take effect on January 1, 1992. The seminar will include information about physician payment reform (RBRVS and Medicare fee schedule), global surgery policy, and the new visit coding. To confirm attendance, please call 609/896-9300.

IN MEMORIAM

MASKELL B. BLACK

We have received word of the death of Maskell Bates Black, MD, on July 5, 1991, at the age of 84. Dr. Black was born in 1906. He attended Hahnemann University, Philadelphia, earning a medical degree in 1933. Dr. Black was a general practitioner. During his long medical career, Dr. Black practiced in Glassboro, and was affiliated with Elmer Community Hospital. Dr. Black received the MSNJ Golden Merit Award. He was a physician for the Glassboro school district and for the Glassboro County Jail. Dr. Black was a member of our Gloucester County component and of the American Medical Association. Dr. Black resided in Williamstown, Glassboro, and Buena. During World War II, Dr. Black served in the United States Army Medical Corps.

JOHN M. CAMPBELL

A member of our Passaic County component, John Malachy Campbell, MD, died on August 3, 1991. Born in Ireland in 1916, Dr. Campbell was awarded his medical degree from the Royal College of Surgeons and Physicians, Dublin, Ireland, in 1947. After immigrating to the United States, Dr. Campbell became a citizen in the early 1950s. He served in the United States Army as a major from 1951 to 1954 and served in the Reserves from 1954 to 1959. He completed an internship at Bellevue Hospital from 1955 to 1957. After receiving a license to practice medicine in New Jersey in 1958, Dr. Campbell maintained offices in Paterson and Oakland. He was affiliated with the Department of Obstetrics and Gynecology at St. Joseph's Hospital and Medical Center, Paterson. He was a member of the Association of Military Surgeons of the United States. He retired to West Palm Beach, Florida, in 1989.

WILFRED CARROL

Word has been received of the death of Wilfred Carrol, MD, on June 17, 1991. A member of our Essex County component, Dr. Carrol was a longstanding associate of Newark Beth Israel Medical Center, Newark, and Clara Maass Memorial Hospital, Newark. Born on March 18, 1909, in Russia, Dr. Carrol was awarded his medical degree from Columbia University College of Physicians and Surgeons, New York, in 1933. He completed an internship at Beth Israel Hospital, New York, and received his license to practice medicine in New Jersey in 1934. Dr. Carrol was a diplomate of the American Board of Internal Medicine; a member of the American Medical Association; and a fellow of the American College of Physicians.

ROBERT A. COOPER

A member of our Camden County component, surgeon Robert Arthur Cooper, MD, died on January 6, 1991. Born in Pennsauken on December 26, 1908, Dr. Cooper attended Temple University School of Medicine, Pennsylvania, earning his medical degree in 1940. He maintained a practice in Camden and resided in Pennsauken and Cherry Hill. Dr. Cooper was affiliated with Cooper Hospital/University Medical Center and Zurbrugg Memorial Hospital, Riverside. Dr. Cooper was a diplomate of the

American College of Surgery, a fellow of the American College of Surgeons, and a member of the American Medical Association. A World War II veteran, Dr. Cooper served in the United States medical corps.

FREDERICK A. FINGER

At the grand age of 90, Frederick A. Finger, MD, died on June 9, 1991. A retired member of our Hudson County component, Dr. Finger was a 1926 graduate of Baylor University College of Medicine, Texas. He was a member of the American Medical Association.

ARTHUR GIFFONIELLO

Arthur Giffoniello, MD, died on August 3, 1991, at the age of 85. A retired member of our Essex County component, Dr. Giffoniello was a proctologist and general surgeon in Newark and Bloomfield for over 55 years. Born in 1905, Dr. Giffoniello was a 1931 graduate of Georgetown University Medical School, Washington, DC; he received his New Jersey medical license the following year. He completed an internship at St. Mary's Hospital, Hoboken. Dr. Giffoniello was a member of the Board of the Clara Maass Medical Center, Belleville; Columbus Hospital, Newark; and Bellevue Hospital, New York. He was a member of the American Medical Association and a fellow of the International College of Surgeons.

ROGER A. GRECO

Seventy-eight-year-old Newark resident, Roger Armand Greco, MD, died on August 13, 1991. Born in Newark on August 14, 1912, Dr. Greco earned his medical degree from the Faculty of Medicine University of Naples, Italy, in 1939. He completed an internship at Passaic General Hospital, and a residency at Essex County Hospital Center, Cedar Grove. In 1946, Dr. Greco received his license to practice medicine in New Jersey. Dr. Greco was a family practitioner specializing in geriatrics. During his long medical career, Dr. Greco maintained a practice in Newark and was affiliated with Columbus Hospital, Newark. He served as clinical and medical director of the Essex County Geriatric Center, Belleville. Dr. Greco was a member of our Essex County component and of the American Medical Association. Dr. Greco retired in 1983.

JOHN J. HAMLEY

Word has been received of the death of John James Hamley, MD, on July 15, 1991. Dr. Hamley was born on December 23, 1913, in Elizabeth; he was awarded a medical degree from New York Medical College, New York, in 1938. The following year, Dr. Hamley received his New Jersey medical license. Dr. Hamley specialized in gastroenterology. During his lengthy career, Dr. Hamley practiced and resided in Elizabeth. He was senior attending at Elizabeth General Medical Center and a consultant at St. Elizabeth Hospital. He also was on staff at Alexian Brothers Hospital, Elizabeth. Dr. Hamley was a member of our Union County component and of the AMA.

JOHN W. HARDY

Longtime physician John William Hardy, MD, died on July 31, 1991. A member of our Monmouth County component, Dr.

Hardy was 83 at the time of his death. A 1934 graduate of Hahnemann Medical College, Pennsylvania, Dr. Hardy completed his internship at Fitkin Memorial Hospital, Neptune, in 1935 to 1957. During his distinguished career, he was director of the Department of Obstetrics/Gynecology and assistant chief of staff at Jersey Shore Medical Center, Neptune. An active member of organized medicine, Dr. Hardy was president of the Monmouth County Medical Society and a delegate to the Medical Society of New Jersey; a member of the American Medical Association; treasurer of the New Jersey Obstetrics-Gynecology Society; a fellow of the American College of Obstetricians and Gynecologists; and a diplomate of the American Board of Obstetrics and Gynecology. He was a flight surgeon in the Air Force from 1943 to 1945 and was awarded three presidential citations during his Air Force enlistment.

GEORGE M. KNOWLES

At the grand age of 91, we have received word of the death of internist George Milton Knowles, MD, on August 22, 1991. Dr. Knowles, born in Chicago, Illinois, on November 30, 1899, was awarded a medical degree from Columbia University College of Physicians and Surgeons, New York, in 1926. Dr. Knowles received his license to practice medicine in New Jersey in 1928. Dr. Knowles maintained a practice in Hackensack for over 50 years. He served as director of medicine at Hackensack Hospital; was attending at Bergen Pines County Hospital, Paramus; and was a consultant at The General Hospital Center at Passaic. Dr. Knowles was a member of the New Jersey and American Diabetic Associations, of the American Heart Association, of the American Medical Association, of the Academy of Medicine of New Jersey, and of our Bergen County component; a diplomate of the American Board of Internal Medicine; and a fellow of the American College of Physicians. Dr. Knowles served in the medical corps during World War II. Dr. Knowles resided in Hackensack and Maywood.

ISSAC E. LEONARD, JR

Barrington resident Issac Edward Leonard, Jr, MD, died on July 8, 1991, at the age of 81. Born in Atlantic City on March 20, 1910, Dr. Leonard was awarded a medical degree from the University of Pennsylvania School of Medicine, Philadelphia, in 1937. Dr. Leonard received his New Jersey medical license in 1939. He served as head of the anesthesiology department at Atlantic City Medical Center, and maintained a general practice in Margate for 30 years, also serving as school physician for the local school system. During World War II, Dr. Leonard served in the United States Army, in hospitals in England, Germany, and Czechoslovakia. Dr. Leonard was a member of our Atlantic County component and of the American Medical Association.

STEPHEN R. LO VERME

Following a lengthy medical career, Stephen Russell Lo Verme, MD, died on August 27, 1991, at the age of 69. Dr. Lo Verme was born in Boston, Massachusetts, on August 30, 1921, and was awarded a medical degree from Boston University School of Medicine, Massachusetts, in 1946. In 1947, Dr. Lo Verme completed an internship at Worcester City Hospital, Massachusetts. He received medical licenses from Washington, DC,

and New Jersey in 1953 and 1958, respectively. Dr. Lo Verme practiced in Washington, DC, and then relocated to New Jersey in the 1950s. A plastic and reconstruction surgeon, Dr. Lo Verme specialized in cosmetic and hand surgery. Dr. Lo Verme served as chief of plastic surgery at the Veterans Administration Medical Center, East Orange, and at the University of Medicine and Dentistry of New Jersey (UMDNJ), Newark; director of the residency training program in plastic surgery at UMDNJ; and attending at Montclair Community Hospital, The Mountainside Hospital, Montclair, The Hospital Center at Orange, and St. Mary's Hospital, Passaic. Dr. Lo Verme was a clinical assistant professor at UMDNJ, Newark. Dr. Lo Verme was a diplomate of the American Board of Surgery and of the American Board of Plastic Surgery; a fellow of the American College of Surgeons; and a member of our Bergen County component and of the American Medical Association. He served as president of the New Jersey Chapter of the American College of Surgeons and of the New Jersey Society of Plastic and Reconstructive Surgeons. Dr. Lo Verme was an advisor to Blue Cross/Blue Shield of New Jersey and served on insurance review committees of the Medical Society of New Jersey. The New Jersey Society of Plastic and Reconstructive Surgeons recently established the Stephen R. Lo Verme Annual Lecture Series and Fund. Dr. Lo Verme was a World War II veteran and served in the active reserves.

HUGH E. MCGEE

Ophthalmologist Hugh Edward McGee, MD, died on July 31, 1991. Born in 1909, Dr. McGee was awarded his medical degree from Long Island College of Medicine, New York, in 1935. He completed an internship at St. Mary Hospital, Hoboken, and a residency at Bellevue Hospital, New York. He received his New Jersey license to practice medicine in 1947. Dr. McGee maintained a private practice in Hackensack since 1953. He was affiliated with Hackensack Medical Center; Valley Hospital, Ridgewood; and Bergen Pines County Hospital, Paramus. Dr. McGee was a member of our Bergen County component and of the American Medical Association; a fellow of the American College of Surgeons and of the American Academy of Ophthalmology. Dr. McGee served in the U.S. Army during World War II.

JOHN POIS

Word has been received of the death of John Pois, MD. Born on March 1, 1902, in New York City, Dr. Pois was awarded a medical degree from New York University School of Medicine, New York, in 1925. He received his New Jersey medical license in 1927. Specializing in internal medicine and cardiology, Dr. Pois maintained a practice in South Orange for 35 years. He was affiliated with St. Mary's Hospital, Orange, and with Essex County Hospital, Belleville. Dr. Pois relocated to California in 1963; he served in the geriatric unit at Carmarillo State Hospital. In 1977, Dr. Pois joined the staff at Senior Citizens Community Medical Clinic, now called Sharp Senior Healthcare, serving as the medical director. Dr. Pois helped to expand the center from a part-time screening clinic into a full-service medical center. Dr. Pois was a member of our Essex County component and of the American Medical Association, and a diplomate of the American Board of Internal Medicine. Dr. Pois was a major in the United States Army Medical Corps, earning a Bronze Star for his efforts during World War II. Dr. Pois resided in South Orange and in California.

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Our gratitude is extended to Mr. Fortunato and the N.J. Department of Insurance for acting quickly to review this new program.

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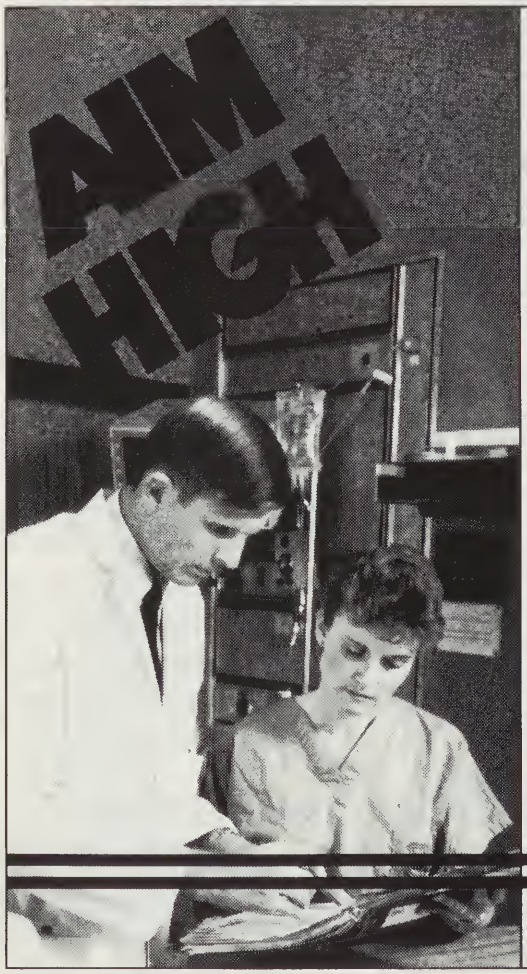
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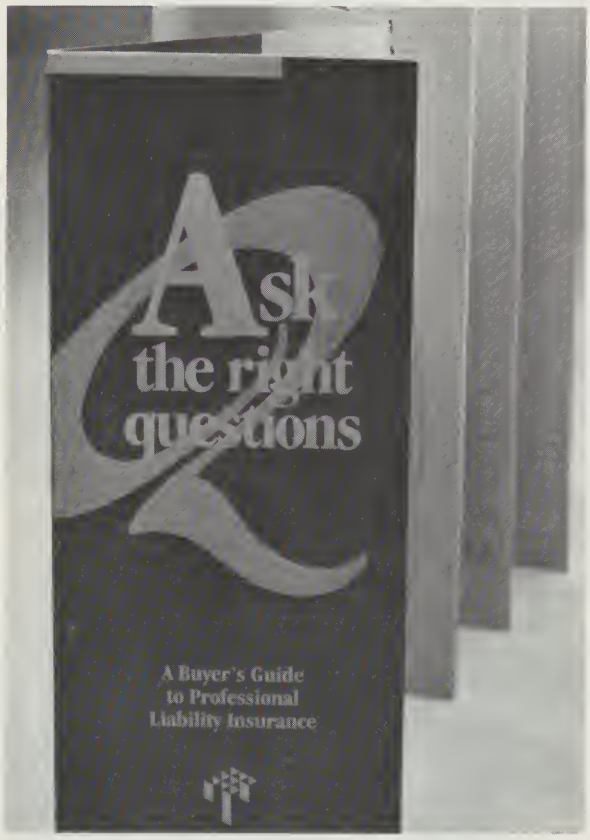
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